STATE TITLE V BLOCK GRANT NARRATIVE
STATE: NY
APPLICATION YEAR: 2006

I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bu

C. ASSURANCES AND CERTIFICATIONS

Assurances and Certifications will be kept on file in the office of the Title V Director, New York State Departr
Family Health, Corning Tower Room 890, Empire State Plaza, Albany NY 12237-0567. In addition, assuranc
reprinted in hardcopy and web-based versions of the block grant application. Hardcopies are available at the
application appears on the New York State Department of Health Website at: www.health.state.ny.us.

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE
APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

I. E. PUBLIC INPUT

The New York State Department of Health, as New York's Title V agency, has several methods for making t
soliciting, accepting and incorporating public input during its development and after its transmittal. These inc

1. using a variety of public interaction processes as first modeled in Communities Working Together for a He
that served as the basis for forming New York's public health priorities for the decade from 1996 to 2006;
2. placing the document on our public website and making hardcopies available through the Division of Fam
3. an active and involved Maternal and Child Health Services Advisory Council, statutorily-established as a r
4. annually establishing public hearings, rotating locations across the State;
5. surveying parents of Children with Special Health Care needs;
6. conducting a series of focus groups with Title V consumers and Title V-eligible groups across the State; a
7. accepting phone calls, letters, faxes and e-mails regarding the content of the document.

Each of these methods is described in more detail under Section II. Needs Assessment.

II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this sec

III. STATE OVERVIEW

A. OVERVIEW

The overall goals for health care delivery in New York are:

• to continue to make available insurance coverage to the uninsured and underinsured;
• to assure that the health care delivered in New York State is of high quality;
• to emphasize prevention and education by involving communities in addressing and improving health; and
• to create a seamless health care system whereby our residents may retain continuous health care delivery irrespective of insurance status.

In addition, Governor Pataki has set these more specific goals for health in New York:

• to reduce potentially deadly asthma attacks in children;
• to ensure that every child in New York receives all their vaccinations by their second birthday;
• to ensure that every newborn is screened for hearing impairment;
• to significantly reduce smoking among youth in New York State; and
• to protect infants born to HIV-infected mothers to ensure that virtually none develop AIDS.

As previously described, New York has undergone extensive priority-setting processes. The ten priorities tha performance measures related to each, stem specifically from areas of unmet need in the State.

The following are New York's maternal and child health services priority needs:
• To improve access to high-quality health services for all New Yorkers, with a special emphasis on prenatal includes attention to mental health issues and which serves those with special health care needs;
• To improve oral health, particularly for pregnant women, mothers and children, and among those with low i
• To prevent and reduce the incidence of overweight for infants, children and adolescents;
• To eliminate disparities in health outcomes, especially with regard to low birth weight and infant mortality;
• To improve diagnosis and appropriate treatment of asthma in the maternal and child health population;
• To reduce or eliminate tobacco, alcohol and substance use among children and pregnant women;
• To reduce unintended and adolescent pregnancies;
• To implement new genetics tests within the statewide system of newborn metabolic screening;
• To reduce the rate of violence across all age groups, including inflicted and self-inflicted injuries and suicid
• To improve parent and consumer participation in the Children with Special Health Care Needs Program, as

Improving and sustaining access to high-quality, continuous primary health care and treatment services are outcomes for all New Yorkers and achieving our public health and maternal and child health priorities. The h prevention, early intervention, and continuity of care through establishing and maintaining a "medical home" New Yorker. Success will also depend on the actual delivery of appropriate, high-quality, comprehensive he and requires practitioners to be knowledgeable about and practice good preventive and therapeutic medicin Office of Medicaid Management and the Office of Managed Care to ensure continuity and coordination with to ensure that any gaps in care are recognized and acted upon.

Please see Section II. Needs Assessment for a more complete description of New York State's geography, p care delivery environment.

Measuring success will rely on accurate assessment of progress. Factors that play a role are:

Diversity: Recapping the Needs Assessment, New York's diverse geography can also present interesting pu has both urban centers and sparsely populated rural areas. New York's beautiful natural resources attract to and recreational attractions, which can produce variable seasonal demand on health services, especially in services and public health. Seasonal variations in weather also affect how and when New Yorkers seek serv snowstorms can delay access to care and make travel dangerous, especially in the northern and eastern are

Our population is even more diverse than our geography, more diverse than the nation as a whole, with Nev diverse area. On the 2000 Census, 67.9% of New York residents reported they were White alone, 15.9% re

American alone, 5.5% reported that they were Asian alone, 0.4% reported they were American Indian or Ala being some other race. 15.1% of the State's total respondents reported that they were Hispanic. Over 3.1% themselves as being of more than one race. Native Americans were severely undercounted.

New York is also home to many new New Yorkers and new Americans. New York ranks higher than the cou Black residents, Hispanic residents, and non-citizen residents. We are second among states for non-citizen 2.2 million resident non-citizen immigrants. 90% of non-citizen immigrants in the State live in New York City. was estimated at 3.4 million in 1995, representing 17.7% of the State's population, or about one in six peopl foreign-born in New York are here legally (84%). 4,704,625 New Yorkers speak a language other than Engli 2,092,875 reported speaking English less than "very well." The ability to communicate is key to ensuring app health care.

Poverty and Health Care: Poverty is major factor for affordability and access to health care services. Accord about 14% of New Yorkers lived below the Federal Poverty Level (FPL) in 2003, and 19% were below 125% families live in households with incomes at or below 100% of the FPL. More New York adults with children th poor. 13.7% of those participating in the Behavioral Risk Factor Surveillance Study in 2004 reported not see due to cost. Figures are higher among African Americans and Hispanics. Un-insurance rate among children the health care needs of the poor, New York has a comprehensive Medicaid package, Child Health Plus, Fa New York.

Pregnancy and Birth Rates: The overall birth rate had been declining, but took a slight upswing in 2002 and pregnancy rates are declining and below national averages. African American and Hispanic teens have nea than White teens, though the rate for Hispanic teens declined noticeably from 1999 to 2003. The rate of unir PRAMS respondents remains mostly stable at 34% during this same time period. Those most at risk for unir those under age 20 (82.2%), women who were not married (61.9%), African American women (60.2%), wom women with less than a high school education (51.9%).

Prenatal Care: The percentage of women entering prenatal care in the first trimester has shown slight impro but leveled off in 2002. In 2003, the rate again improved to almost 75%. The most dramatic increase in first York City residents (from 55.5% in 1993 to 67.7% in 2001 and 2002 and 71.9% in 2003) and among Hispan (48.1% to 67.4% and 50.8% to 64%, respectively). During that same time period, adequacy and content of p regions and among all racial and ethnic groups.

Other positive trends in the PRAMS data were noted from 1996 to 2002:
• Fewer mothers reported drinking alcohol while pregnant.
• Fewer mothers reported smoking prior to, during, and after pregnancy.
• Fewer mothers exposed their babies to second-hand smoke.
• Fewer mothers experienced physical abuse during pregnancy.
• More mothers initiated breastfeeding.
• More mothers place their babies on their backs to sleep.
• More mothers had knowledge of the positive effects of folic acid on birth defects.

Prenatal care enrollment increased among HIV+ women and more women presenting for delivery had receiv during pregnancy. The percent of HIV-exposed infants who received prenatal, intrapartal or neonatal ARV to increased. As a result of these efforts, neonatal HIV infection rates are declining.

Low and Very Low Birth Weight: Overall rates of low birth weight and very low birth weight have been relativ years. The rate for singleton births has declined, indicating that the increase in multiple births seems to be re overall rates. Though disparities in low birth weight rates have shown some improvement over time, they stil American singleton births have declined, as have rates among Latina births, though less dramatically in the year increase in 2002. Between 2000 and 2003, rates for these populations increased slightly or leveled off.

Maternal Mortality: Wide fluctuations in rates appear to be a result of the rarity of the occurrence and the zea Rates are highest in New York City and among African American women. The overall 2003 rate of 20.9 per Healthy People 2010 goal of 3.3 per 100,000. The overall rate includes rates among White mothers at 13.2 mothers at 9.1 per 100,000, and for African American women at 52.4 per 100,000. The ratio of Black-to-Whi

4.0.

Children: There were some very encouraging and some not-so-encouraging trends.

A survey of WIC participants showed more children are drinking low-fat or skim milk and more fruits and veg
that group. However, overweight in children is still increasing. The 2003 YRBS found 9.3% of females and 1
overweight. In 2003, 16.7% of all children ages two to four enrolled in WIC were overweight. Hispanic childr
almost twice as likely to be overweight than Black or White children. The 2003 YRBS found that 43.6% of N
surveyed watched three or more hours of television per day.

Although asthma hospitalization rates increased between 2002 and 2003, rates are down from a high in 199
otitis media. The incidence and prevalence of childhood lead poisoning are declining and childhood immuniz
syphilis rate among teens declined. SIDS deaths and infant mortality rates continued to decline, with Hispan
per 1,000, compared to 5.2 per 1,000 for the White population and 9.5 per 1,000 for the Black population. N
also continue to show an overall decline.

With regard to risk-taking behavior, the 2003 YRBS showed seat belt and bike helmet use increasing, fewer
fewer students feeling sad or hopeless everyday. New York has a lower percentage of sexually active teens
More New York teens reported using condoms at last intercourse than teens in the rest of the country. Howe
being afraid for their safety at school.

Children with Special Health Care Needs and their Families: New York is in receipt of SLAITS data on Child
Needs, and has designed a plan for further analysis. These data will prove helpful in development of further
and their families. At this time, SAITS data will serve as a baseline against which New York measures future
have testified as to what makes medical care a "medical home" and what types of support they need from th
already at work on some of these issues. (See program plan.) The addition of the Champions of Progress in
involvement in policy and planning.

Health Insurance: New York's public insurance programs include the Medicaid program, Child Health Plus a
are additional health insurance programs that assist small businesses and people who have lost health insu
products. Data from the National Survey of American Families shows New York to do better than the US ave

Health Care Access: Health care access is most difficult for the uninsured, those with less education and tho
not English. Other barriers to access include high out-of pocket-expenses, lack of public transportation and a
professionals, especially dentist and specialists that are willing to accept Medicaid as payment.

B. AGENCY CAPACITY

The New York State Department of Health, as the Title V agency in New York State, plays a major role in as
essential maternal and child health services. Title V, the Maternal and Child Health Services Block Grant, pr
provision of all maternal and child health services by the New York State Department of Health.

Please see a full description of agency capacity as it appears in the Needs Assessment.

Title V Roles and Responsibilities: The Title V role of the New York State Department of Health includes:

• assessing and monitoring maternal and child health status to identify and address problems;
• diagnosing and investigating health problems and health hazards affecting women, infants, children and yo
• informing and educating the public and families in New York State about maternal and child health issues (
educate and inform us, as well);
• mobilizing partnerships between policy makers, providers, families and the public to identify and solve mat
New York State;
• providing leadership in priority-setting, planning and policy development to support county and community
women, infants, children, youth and their families;
• promoting and enforcing legal requirements that protect the health and safety of women, infants, children a

to ensure public accountability for their well being;
• linking women, their infants, children and youth to health and other human services and to assure access t
systems of care;
• assuring the capacity and competency of the public health/maternal and child health workforce to effective
health needs within the State;
• evaluating the effectiveness, accessibility and quality of personal health and population-based maternal an
• supporting research and demonstrations to gain insights and innovative solutions to maternal and child hea

Assessing and monitoring maternal and child health status to identify and address problems: Please refer to
of this document, which reflects our structures and capacity to gather, analyze and report data across a vari

NYSDOH is able to track problems and hazards specific to the maternal and child health population, includir

• vital events (births, deaths, fetal losses, causes of death);
• vaccine-preventable and other diseases and conditions affecting the maternal and child health population (
caries, unintended pregnancies, injuries);
• perinatal conditions of the newborn and mother (low birth weight, very low birth weight);
• sentinel events;
• service usage;
• knowledge, attitudes and behaviors of mothers and youth; and
• treatment experience of at-risk infants and toddlers.

Likewise, NYSDOH and the Title V program are able to prepare, analyze and report information about the m
population to inform needs assessment, planning and policy development, including, but not limited to:

• population demographics (age, race, ethnicity);
• socioeconomic conditions (poverty, employment, insurance coverage);
• behavioral and other health risks (teen drinking, smoking, seat belt use, drug use); and
• health status (morbidity and mortality rates);
• health services utilization (early trimester prenatal care, immunization coverage); and
• public perception of health problems and needs (block grant public hearings, focus groups).

NYSDOH maintains and active public website at www.health.state.ny.us and has additional intranet sites for
department use and for the use of health providers. Our public website gets about 32,452,344 hits annually.
Set is more fully described in the Needs Assessment.

Diagnosing and investigating health problems and health hazards affecting women, infants, children and you
addition to its normal surveillance activities, Title V and the NYSDOH maintains the capacity for conducting
special studies involving such areas as communicable diseases, childhood lead poisoning, oral health, mate
substance use, and smoking.

Informing and educating the public and families in New York State about maternal and child health issues: T
Healthy Hotline, provides expertise and fiscal support for development of printed and promotional materials,
educational experiences. A more thorough discussion of some of DOH's recent maternal and child health re

Through public hearings, focus groups, libraries and web postings, we encourage the public to educate and
In this grant year, under the auspices of the Maternal and Child Health Services Block Grant Advisory Coun
held in various locations across the State. An additional five focus groups were held. We strive to make all m
linguistically-, and age- appropriate. Consumers are paid for their time, childcare and travel expenses to par
required our contractors to provide translations services, as appropriate, and to provide nutritious, culturally-

Mobilizing partnerships between policy makers, providers, families and the public to identify and solve mate
New York State: The Title V agency develops and provides materials and mechanisms for dissemination of
child health status and services, needs, and gaps in addressing needs to policy makers, health delivery syst
and the general public. Please refer to the Needs Assessment for a listing of partners and examples of colla
betterment of the maternal and child health population.

Providing leadership in priority-setting, planning and policy development to support county and community e
women, infants, children, youth and their families: The Title V agency has developed and promoted an MCH
2010 and Communities Working Together for a Healthier New York as our framework. The NYSDOH also p
infrastructure/communication structures for collaborative partnerships in the development of MCH needs ass
and programs through:

• providing routine communications (newsletters, website postings and links, technical assistance workshop
Administrator" letters, mass mailings, and, if the need arises, through a provision of in the Public Health Law
which allows the State Commissioner of Health to summon the commissioner or public health director of eac
• convening advisory councils, task forces or workgroups composed of consumers, business, community org
and/or others to review health data and make recommendations;
• convening and staffing commissions and advisory councils for the oversight of maternal and child health se
recommending resource allocation; and
• providing funding and support for parent networks and coalitions.

It is the information gathered in performance of its essential roles and responsibilities that, taken together wi
trends and systems of care, form the strategic process that determines the priorities for Title V effort.

Promoting and enforcing legal requirements that protect the health and safety of women, infants, children ar
to ensure public accountability for their well being: The Department works with our Office of Governmental A
Affairs to help ensure consistency in legislative mandates, to resolve inconsistencies, to write regulations an
across family and child-serving programs. Title V provides expertise in development of legislation and regula
contractors to adhere to all required regulations and contractual obligations and ensures compliance throug
Contractors and health plans are required to regularly report on health services process and outcome meas

To help protect the health and well being of our MCH population, New York State has a strong legislative ba

• MCH-related governance and the organization and function of advisory bodies;
• MCH practice and facilities standards, including standards for all hospitals and freestanding diagnostic and
high-risk perinatal care and for educational and practical preparation of health care providers;
• uniform data collection through vital records and statewide registries;
• public health reporting of communicable diseases, births and deaths, child abuse and other adverse events
• environmental protections, such as indoor smoking laws, firearms control, traffic safety, and regulations co
temporary (farmworker) housing, use of pesticides and toxic chemicals in schools, swimming pools and bath
• access and quality assurance monitoring required by public insurance programs.

The Title V program in New York takes a role in development, promulgation, and regular review of statutes,
guidelines related to health services delivered and funded through the public and private sectors. For examp
to review and update a provider manual containing standards for health supervision under New York's EPSD
Health Program. Title V staff regularly interact in such matters with WIC, Title X, Title XIX, and Part H (IDEA
in certification, monitoring, onsite reviews and quality improvement activities of health plans and public healt
services, standards and regulations. Title V staff have also been involved in review of care of children in fost

Linking women, their infants, children and youth to health and other human services and to assure access to
systems of care: Title V and the NYSDOH provide a range of outreach interventions including street-level ou
targeted efforts to reach MCH populations that can be hard to find, hard to keep engaged and/or hard to kee
unique life circumstances (homeless women who move frequently, geographically isolated women and famil
those of different languages and cultures).

DOH provides culturally- and linguistically-appropriate staff, resources, materials and communications, eithe
contractors. The availability and use of toll-free telephone information and referral lines, resource directories
enrollment assistance greatly assists in this effort. Please see the description of the Growing Up Healthy Ho
and the use of the AT&T Language Line in the Needs Assessment.

Title V monitors public response to health plans, facilities and public provider enrollment practices with respe

of required forms and procedures, orientation of new enrollees, and ease of access to care, and has provide risk, or hard-to-reach individuals and in using effective methods to reach them.

Title V also provides, arranges or administers women's, children's and adolescent health services, and spec special health care needs. We provide, generally through contractual services, those gap-filling services not health plans or mainstream benefits packages, such as school-based primary care and dental services, sch services, care coordination, public health nursing or social work, community health worker services and den have universal screening programs for genetic/metabolic disorders, hearing impairment, and perinatal HIV. providers to screen children for childhood lead poisoning at ages one and two.

Assuring the capacity and competency of the public health/maternal and child health workforce to effectively health needs within the State: NYSDOH provides the infrastructure and technical capacity for efforts to ensu health/maternal and child health workforce training efforts.

• Title V staff serve as faculty to the University at Albany's School of Public Health (SPH), in a unique arrang active State Health Department, provides the learning laboratory for SPH students.
• Title V provides paid internships and graduate assistantships to graduate students in public health to work related to Maternal and Child Health.
• Title V and other NYSDOH staff serve on the University at Albany School of Public Health's Continuing Ed Leadership Institute Advisory Councils.
• NYSDOH sponsors both a Preventive Medicine Residency Program for physicians and a Dental Public He dentists.
• Title V sponsors regular satellite broadcasts on current issues in public health and maternal and child healt
• Title V sponsors Healthy Children New York, an effort that educates public health nurses and public health consultation to child-serving agencies, such as child care providers. Staff also participate in efforts with the Services to educate child care providers in health and safety issues through their satellite broadcast system
• Title V and NYSDOH staff work with their community partners to educate the public and providers in their a areas such as asthma and women's health.
• Title V staff provide workshops on community health assessment, use of data, and best practices to impro child health population.
• NYSDOH commissions studies of health workforce issues.

Evaluating the effectiveness, accessibility and quality of personal health and population-based maternal and Department regularly reviews program effectiveness and uses information to formulate responsive policies, has the capacity to develop surveys and profiles of health status, health care access, and health care availa distribution, hours of service, etc.), as well as profiles of consumer and provider knowledge, attitudes and be identify and report on barriers to care and collect and analyze information on community and constituent per communities.

Title V supports a number of gap-filling direct services programs, such as the School Health Program, Famil Health Program. All funded programs are regularly reviewed for quality by DOH staff.

Supporting research and demonstrations to gain insights and innovative solutions to maternal and child heal examples of the research to gain insights and innovative solutions are the oral health surveillance initiative, and a joint CDC project to further analyze New York State-specific information from the SLAITS survey of C Needs. Title V also funds 12 graduate assistantships per semester, allowing graduate students in public hea into current research issues in maternal and child health.

NYSDOH also has an active Institutional Review Board that sponsors researcher training and reviews all re health department-related research, and registry data. Title V staff serve on this important agency review bo

The Title V agency continues to play a major role in assuring the quality and access to essential maternal a York State. The Title V programs have worked to ensure that the transition to a negotiated rate system and managed care enable women, infants and children to receive high-quality, comprehensive, appropriate serv maternal and child health services are strengthened by this transition, and that the public health safety net e protects vulnerable populations. We do so in the context of careful, coordinated department-wide and statev

collaboration with other State agencies and private organizations, and State support for local communities.

A list of major program objectives appears in the appendix of the application.

C. ORGANIZATIONAL STRUCTURE

As previously stated in the Needs Assessment, the responsibility for New York's Title V Program is located v
Department of Health, Center for Community Health, Division of Family Health, which is "responsible for the
the administration) of programs carried out by Title V." [Section 509(b)]

The New York State Department of Health is an executive agency, with Commissioner Antonia C. Novello, M
directly to Governor George E. Pataki. Maternal and child health programs are located throughout the Depa
the Center for Community Health and the Division of Family Health, where administrative oversight for the B
to its responsibility for Title V, the Division of Family Health is responsible for family planning (Title X), early
services, the Prenatal Care Assistance Program, perinatal networks, designation of perinatal centers and CS
health, lead poisoning prevention, adolescent health, youth development, adolescent pregnancy prevention,
screening and programs for children with special health care needs.

The State Health Department's organizational chart is included with this submission in the Appendix. Organi
support our mission, vision and values.

Division of Family Health has four Bureaus:

• The Bureau of Child and Adolescent Health;

Title V and Title V-related programs within the Bureau of Child and Adolescent Health include: Childhood Le
Pediatric Asthma, Healthy Children New York, Children with Special Health Care Needs (including the Fami
Handicapped Children's Program, Youth Development, the School Health Program, the School Health Infras
Youth, Abstinence Education, the Community-Based Adolescent Pregnancy Prevention Program, Enhanced
Mortality Review, Interim Housing for Lead Poisoned Children and their Families, the Regional Lead Poisoni
Centers, and the Gay, Lesbian, Bisexual and Transgendered Youth Initiative. BCAH also has responsibility f
Comprehensive Services Initiative.

• The Bureau of Dental Health;

Title V and Title V-related programs within the Bureau of Dental Health include Dental Public Health Educati
High-Risk Underserved Children's Program/Dental Sealant Program, the Fluoride Supplementation Program
Residency Program, Oral Health Surveillance and Dental Research, the Dental Rehabilitation (Orthodontia)
Services, and School-Based Dental Services.

• The Bureau of Early Intervention Services; and

The Bureau of Early Intervention Services administers the Part C/IDEA programs and the Universal Newbor
This Bureau is also responsible for publication of "Welcome to Parenthood," a publication received by all ne
New York State's hospitals.

• The Bureau of Women's Health.

Title V and Title V-related programs within the Bureau of Women's Health include the Family Planning Progr
Healthy Hotline, the Community Health Worker Program, Comprehensive Prenatal/Perinatal Services Netwo
Assistance Program (PCAP) and the Medicaid Obstetrical Maternity Services (MOMS) Program, the Lactatio
Medicine Residency Program, the Coordinated Women's Health Program, the Osteoporosis Program and A
Mortality Review, and the Statewide Perinatal Data System, and designation of all birthing hospitals for perir
works with the AIDS Institute on the Community Action for Prenatal Care (CAP-C) Program.

The Division of Family Health directly administers SSDI, the American Indian Health Program, the Columbia

Education Project, the Asthma Collaborative, and Migrant Health Services. Genetics Services and the Newb
Program are administered by NYSDOH's Wadsworth Laboratories. The Congenital Malformations Registry i
Environmental Health.

A more complete description of the agency's capacity appears in the Needs Assessment.

D. OTHER MCH CAPACITY

The Division of Family Health continues responsibility for coordinating MCH-related programs and directly m
initiatives.

Statutory Authority: The New York State Public Health Law provides statutory authority for various maternal
including establishment of health departments and health care facilities and agencies, qualifications of publi
screening, lead poisoning prevention, immunization, and health care financing.

Article 6 of the Public Health Law authorizes payment of State Aid to Localities for certain public health servi
child health services.

The New York Code, Rules and Regulations (NYCRR) interpret how Public Health Laws are to be implemer

State Budget Bills delineate the use of State funds, including for public health and maternal and child health

State Finance Law provides the requirements for management of State funds and federal funds coming thro
the Public Health Law relates to Grants In Aid.

State Education Law regulates the professions, including physicians, nurses, nurse practitioners, medical sc
therapists and midwives.

Chapter 884 of the Laws of 1982 outlines the composition and responsibilities of the Maternal and Child Hea
Council.

Statutory Authority for childhood lead poisoning prevention and intervention is found in Section 206 of the Pu
Article 13, the Lead Poisoning Prevention Act. Regulations are contained in Sub-Part 67-1.

Article 25 of the Public Health Law covers Maternal and Child Health, with Title I- General Provisions, Title II
Midwifery, Title IV - Institutions for Children, Title V - Children with Physical Disabilities, Title VI is expired, T
Public Education.

The Children with Special Health Care Needs Program is authorized by Title V of the federal Social Security
Health Law 2580.

Article 27-C relates to the Birth Defects Institute, 27-D relates to Burn Care, and 27-E and F relate to HIV an

Final regulations on universal newborn hearing screening appear in Subpart 69-8 of 10 NYCRR.

Abstinence Education is authorized by Public Health Law 104-193 and the federal Personal Responsibility a
(Welfare Reform).

The American Indian Health Program is administered pursuant to Public Health Law SS 201(1)(s), under wh
to "administer to the medical and health needs of the ambulant sick and needy Indians on reservations."

Comprehensive Prenatal/Perinatal Services Networks are authorized under the legislation authorizing the Pr
Program, Public Health Law 2522, which includes a provision for outreach, public education and promotion c
benefits of preconception health care and early and continued prenatal care.

The statewide Early Intervention Program was established in Public Health Law Title II-A, Article 25 in 1992.

Family Planning is authorized under federal Title X and 10 NYCRR 42CFR, 43CFR, 45CFR, BCHS Guidelin

Chapter 198 authorizes the Health and Education Departments to certify school-based health centers and s

Laws relating to public health are described on the Department's public website, www.health.state.ny.us/nys
all New York State laws and regulations are available on the world wide web at this address: http://unix2.nys
necessary assurances and certifications are kept on file in the office of the Title V director and can also be fo
website; www.health.state.ny.us/nysdoh/grants/main.htm

E. STATE AGENCY COORDINATION

The New York State Department of Health has formalized relationships with other state agencies, local publ
qualified health centers, tertiary care facilities, academic institutions and the non-profit voluntary sector, whic
the Title V program.

Agreements with Other State Agencies
State agencies are coordinated at the level of the Governor's cabinet. The Department of Health is a party to
memoranda of understanding with other state agencies. These agreements serve to formalize collaborative
partner agencies.

• The State Education Department (SED) is responsible for general supervision of all educational institutions
certain educational and cultural institutions, for certifying teachers, and for certifying or licensing practitioners
department's supervisory activities include chartering all schools, libraries and historical societies; developin
curricula; accrediting colleges and university programs; allocating state and federal financial aid to schools;
vocational rehabilitation services. The State Education Department administers the Youth Risk Behavior Sur
collaboration. NYSDOH also collaborates with the Education Department on issues such as placement of au
schools, administration of fluoride rinse programs, issues related to the healthcare/public health workforce, s
transition from early intervention to preschool programs, and approval of school-based primary care and den

• The Department has a Memorandum of Understanding with the State Education Department regarding sch
coordination. This memorandum supports the statewide implementation of comprehensive school health and
School Health and Wellness Centers help school districts across the State create positive learning environm
that model and encourage students to engage in healthy behaviors create an atmosphere for academic succ

• As the lead agency for the Early Intervention Program, the Department has letters of agreement with the C
of Mental Retardation and Developmental Disabilities, the State Education Department, and the Office of Alc
Services related to the implementation of this program.

• The Office of Children and Family Services (OCFS), the Council on Children and Families, and the Office o
Services collaborate with DOH on several very important initiatives such as the State Incentive Cooperative
State Alliance for Family Literacy. The Office of Criminal Justice Services, the Department of Labor and the
Disability Assistance participate.

• The Office of Children and Family Services also administers the Adolescent Pregnancy Prevention and Se
providing prenatal support and parenting education to high-risk teens in high need communities.

• The State Legislature allocated funding from the federal Temporary Assistance to Needy Families (TANF)
of Health for outreach and education activities to prevent unintended pregnancies and for School Health. Th
Memorandum of Understanding with the Office of Temporary and Disability Assistance to provide for the tra
Department. This office is also the lead agency for the Teenage Services Act (TASA) Program, providing se
teens on Public Assistance.

• The Office of Mental Health and Office of Children and Family Services collaborate with the Department of prevention. All three agencies sent representatives to the Region 1 and 2 Suicide Prevention Planning Conf

• DOH Title V staff work with the Office of Children and Family Services on health care of children in foster c health and safety of infants and children in child care.

Other State Agency Collaborations
• The Touchstones Initiative, with the Council on Children and Families as the lead agency, began as a colla agencies that fund programs for children and families. State agencies were challenged to agree on the bene consistent, measurable terms. The Team established a Kids Wellbeing Indicator Clearinghouse (KWIC) on t which is to make vital youth statistical information more timely, accessible and usable to communities.

• The New York State Youth Development Team is a partnership established in 1998 by more than two doze organizations. The partnership has lead efforts to develop and promote youth development strategies acros systems in New York State. Agency team members include all major state agencies serving youth (health, n assistance, juvenile justice, substance abuse), as well as the New York State Nurses Association, Cornell U Association of Youth Bureaus, the Mount Sinai Adolescent Health Center the Association of Family Service Safety, University of Buffalo, Families Together of NYS, University of Rochester, the Schuyler Center for An Conference of Local Mental Hygiene Directors, and the Counseling Association. The Team's vision is for far partnering to support the development of healthy, capable and caring youth.

The Youth Development team has guided the creation of several cutting edge products, events and initiative Governor's Blueprint for Youth; local youth development partnerships and centers for excellence under the A for Youth initiative; a briefing paper on youth development, a cross-system initiative to prevent childhood ove Hard; a youth development resource book for communities; and a symposium on outcome indicators for you currently developing a compendium of outcome indicators for state and local use in measuring youth develo

• The goal of Coordinated Children's Services Initiative (CCSI) to improve local service coordination for child serious emotional disturbances and to reduce reliance on residential placements. The lead agencies are the and the Office of Alcohol and Substance Abuse Services. Agency partners include the Department of Health Family Services, the Office of Mental Health, the Office of Mental Retardation and Developmental Disabilitie Substance Abuse Services.

CCSI has recently developed a comprehensive set of recommendations for improving services to children a systems need. Particular emphasis will be placed on developing best practices resource for counties, provid improving CCSI data and outcome collection.

• The goal of Family Support New York is to transform public/private systems and services to support and fo New York State. The Council on Children and Families is the lead agency. Other members include the Depa of Health, the Office of Children and Family Services, the Office of Mental Health, the Office of Mental Retar Disabilities, the Family Development Association of New York State, Family Support NYS, and various comm representatives.

Other Collaborations
• Healthy Start: Many of the federal Healthy Start grantees are also grantees of New York State Department Comprehensive Prenatal/Perinatal Services Network initiative. The Networks were initially funded under Titl different source of funding. However, the need for close association with Title V programs continues in orde effectiveness. The Department holds periodic meetings (at least two per year) with Healthy Start grantees in communication, explore areas for potential collaboration and share late-breaking developments. The Health Title V in evaluating focus group methods and provided feedback that will be incorporated in planning for the groups. Regional staff meet with the Networks on a routine basis

• Local Health Departments: County health departments continued to play an essential role in the assurance maternal and child health services. They assessed the needs of their local communities, worked with their c implement programs that meet those needs, and evaluated the effects on their communities.

Under New York State Public Health Law, local health departments extend the powers of the state health co
provide community health assessment, family health services, health education and disease control services
environmental services. Counties that do not provide their own environmental services rely on the State Hea
in their area. Most counties also operate certified home health agencies or licensed home health care agenc
a variety of home-based services, including skilled nursing, home health aide, therapies, early intervention, r
disease control visits. Most counties also operate diagnostic and treatment centers operated under Article 2

Under Article 6 of the New York State Public Health Law, local health departments perform comprehensive c
and subsequently produce a Municipal Public Health Service Plan. Plans address the needs of the maternal
health education, infant mortality prevention, child health, family planning, chronic disease prevention, injury
nutrition. Title V provides technical assistance to local health units in plan development, participates in the re
implementation. Because local health departments know local systems and community needs, Plans addres
private resources, and across the continuum of primary, secondary and tertiary care. Local health units play
collaborations.

• New York State has a long-established system of highly specialized Regional Perinatal Centers (RPCs). Th
level clinical care to high-risk mothers and newborns, and also serve as important contact points for the Dep
interactions with the health care community. They help ensure that high-risk mothers and newborns receive
working with their affiliate hospitals to monitor perinatal morbidity and mortality and to provide education and
physicians and others. The Regional Perinatal Centers not only serve as the hub for consultation and transp
quality improvement activities within their network. All birthing hospitals in the state, including Regional Perin
and redesignated in 2001.

• Area Health Education Centers (AHECs) work to recruit, retain, and support health professionals to practic
provider shortages, developing opportunities and arranging placements for future health professionals to rec
underserved areas, and providing continuing education and professional support for professionals in these c
local youth to pursue careers in health care. The MCH Advisory Council, the State Health Department and th
concerned about the aging of the health care workforce; the aging of nursing and dental faculty; current and
health professions; and in interesting young people in health careers early in their student careers. The Bure
with AHECs and local rural health networks to improve access to primary dental care in rural areas.

• The University at Albany School of Public Health is unique in that it is jointly sponsored by a university and
New York State Department of Health serves as the laboratory for the University at Albany School of Public
working shoulder-to-shoulder with practicing professionals in the state health department or in local departm
Title V staff serve as faculty and advisors to the school. Title V staff also serve on the School's Continuing E

• Title V staff coordinate the MCH Graduate Assistant Program, under which fourteen University at Albany g
(fall, spring and summer) are supported by block grant funds to work on priority MCH research and planning
supports the Department of Health's mission through attracting bright, motivated individuals who are interest
practical knowledge of public health and maternal and child health. The relationship with the University enha
capacity, and improve the availability of pertinent and timely educational offerings for practicing public health

• The University at Albany's School of Public Health sponsors the Northeast Public Health Leadership Institu
northeast corner of the US. Several Title V staff have attended the Institute. Several graduates of the Institut
states and at the New York City Department of Health. Title V staff and Dr. Birkhead serve on their advisory

• The Department also maintains a relationship with the Columbia University School of Public Health through
Initiative. Metropolitan Area Regional Office staff serve as advisors and contract managers to the program. C
health faculty identify current issues in maternal and child health, and apply public health theory and practice
solutions to those issues.

• New York has three University-Affiliated Programs who offer Leadership Education in Neurodevelopmenta
the University of Rochester, the Westchester Institute at Valhalla, and Jacobi/Albert Einstein Medical Center
leadership training in the provision of health and related care for children with developmental disabilities and
and their families. The Department works with the LENDs on a variety of issues related to children with spec
meet training needs, and the University Affiliated Programs are a great source for physician consultants on a

LEND fellows recently traveled to Albany to meet with Title V staff in the Division of Family Health and to dis
Several LEND fellows attended an orientation to Title V sponsored by the New York Medical College, Schoo

• Title V and the Adolescent Coordinator maintain linkages to the Leadership Education in Adolescent Healt
University of Rochester. The purpose of LEAH is to prepare trainees in a variety of professional disciplines f
and academic sectors and to ensure high levels of clinical competence in the area of adolescent health. Tra
developmental, emotional, social, economic and environmental sciences, within a population-based public h
coordination and communication are stressed.

• New York's Pediatric Pulmonary Center is located at Mount Sinai Medical Center in Manhattan. The Pedia
interdisciplinary approach to developing health professionals for leadership roles in the development, enhan
community-based care for children with chronic respiratory diseases and their families. In addition serving a
interdisciplinary training, Mount Sinai also engages in active partnership with state and local health agencies
and research related to chronic respiratory conditions in infants and children.

• Montefiore Medical Center sponsors the Behavioral Pediatrics Training Program. Training grants from the
Health Bureau support faculty who demonstrate leadership and expertise in the teaching of behavioral pedia
community service. Fellows who have completed training are board-eligible in pediatrics. The three-year fell
work and clinical practice in growth and development, adaptation, injury prevention, disease prevention and
is also available to provide continuing education and technical assistance.

• Montefiore is also the sponsor of the Prenatal Education and Awareness of Safety (PEAS Project), through
PEAS Project has implemented a model domestic violence protocol for recognition and intervention with clie
consists of professional education, the addition of an on-site domestic violence coordinator, a public health c
community education, the use of a standardized tool as an avenue for disclosing abuse, and systems chang
practice (chart prompts, documentation forms, inclusion in quality assurance). Their focus is on prenatal pati
procedures are applicable to all women and men who are abused.

• The Department of Health, with the School of Public Health at the University at Albany, the New York State
and the New York State Association of County Health Officials, sponsors monthly Third Thursday Breakfast
provides statewide continuing education opportunities covering a variety of public health issues. Local site c
health department coordinate local logistics. Out-of-state attendees can locate sites by visiting the University
www.albany.edu/sph/coned/t2b2site.html. Continuing medical and nursing education credits are available. S
Children's Health, Quality of Life, Emergency Preparedness, Promoting Healthy Behavior, and Model Progra

• The Office of Children and Family Services also sponsors with partners such as DOH, the SUNY Distance
York State Child and Family Trust Fund, monthly satellite broadcasts on child health and safety topics such

• DOH strives to maintain positive and collaborative relationships with several not-for-profit, voluntary groups
health and well-being of mothers, infants, children and women of childbearing age. The Department's Title V
relationships/collaborations.

Please see pages 109-110 in the Needs Assessment section for a list of active collaborations.

F. HEALTH SYSTEMS CAPACITY INDICATORS

#01 Health Systems Capacity Indicator
The rate of children hospitalized for asthma (per 10,000 children less than 5 years of age)

Rates went from 65.8 in 1998, to 81.5 in 1999, to 62.9 in 2000, to 66.6 in 2001 and 65.4 in 2002. It appears
downward trend, as rates have been decreasing over the last ten years. In 2003, asthma hospitalizations inc
age group. Rates continued to be higher in New York City, compared to the rest of the State. We are continu
continue implementing the Statewide Asthma Plan.

Program efforts to improve rates include:

• Posting current morbidity and hospitalization rates on the Department's Health Information Network (HIN);
• Further describing the burden of asthma among the Medicaid population through the Asthma Medicaid Lin
• Distributing the 2004 Asthma BRFSS Newsletter to all asthma stakeholders, and also posting it on the web
• Implementing a new electronic Asthma Coalition quarterly reporting system;
• Issuing a new Request for Applications;
• Expanding data collection for the Healthy Neighborhoods Program and beginning an evaluation project;
• Monitoring the School Health Asthma Management Program and conducting formal evaluation to determin
be expanded to additional schools;
• Publishing and distributing the New York State Asthma in Schools Handbook;
• Monitoring the outcomes of asthma care management in school-based health centers;
• Continuing implementation of the NYS Asthma Consensus Guidelines and corresponding evaluation and n
• Identifying priority companion toolkits to support the application of the Asthma Guidelines at the patient, pri
plan levels;
• Participation in the Center for Health Care Strategies Collaborative: Improving Asthma Care in New York S
planning the 2005 Asthma Summit;
• Linking and analyzing School Nurse and Head Custodian surveys, school district hospitalization rates, the
the Fire Safety Report data;
• Distributing work-related asthma materials (brochures, cards, toolkits) in conjunction with the Asthma Coali
• Increasing the number of child health promotion specialists who are able to assist child care centers in pre
through Healthy Children New York.

#02 Health Systems Capacity Indicator
The percentage of Medicaid enrollees whose age is less than one year who received at least one initial perio

Idiosyncrasies in data sources and analysis make these data hard to interpret. It appears we are on an upwa
years of data consistency. Percentages were 74.9 in 2002 and 74.9 in 2003.

Program efforts related to this indicator include:
• Every child born in New York State is screened by the NYS Newborn Screening Program for over 40 cong
children early and ensuring they are enrolled in comprehensive specialty care, the rates of morbidity, mortali
reduced.
• HEDS and fee-for-service Medicaid data are tracked to provide feedback on utilization and completion of r
• The Statewide Perinatal Data System is used to enroll newborns in Medicaid at birth.
• Title V services assist with Medicaid and Child Health Plus enrollment and support, enable or provide scre
Child Health Plus enrollees and others.

#03 Health Systems Capacity Indicator
The percent of State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one ye
periodic screen

These data remain about stable or increasing: 62.0 in 2001 and 67.0 in 2002 and 2003. Please refer to the d
above (#02).

#04 Health Systems Capacity Indicator
The percent of women (15through 44) with a live birth during the reporting year whose observed-to-expecte
or equal to 80% on the Kotelchuck Index

The data had been trending toward improvement until 2000. There was a one-year decrease from 2000 to 2
unchanged from 2001 to 2002, at 63.5% and 63.6% respectively. In 2003, the rate was again down slightly t

For a description of program efforts please refer to the discussion of Performance Measures related to prena

#05 Health Systems Capacity Indicator
Comparison of health systems capacity indicators for Medicaid, non-Medicaid and SCHIP programs for infan
pregnant women

In general, health outcomes are less favorable for those of lower socioeconomic status than those that enjoy Medicaid populations generally fair less favorably than privately insured populations with regard to low birth rates of early prenatal care and adequacy of prenatal care. This is not totally related to the source of payme attributable to a confluence of factors.

Program efforts to support elimination of disparities include the analyses provided by the Public Health Infor the use of focus groups to gather information directly from consumers. Findings are discussed with various p

#06 Health Systems Capacity Indicator
The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs for infants (birth to ag women

Medicaid: Pregnant women and infants under one year of age, at or below 200% of the Federal Poverty Lev Medicaid. Women are eligible for family planning based solely on the woman's income being below 200% of regardless of previous Medicaid eligibility or pregnancy. If women are on New York State Medicaid at the tim eligibility, they are eligible for 24 months of continuous family planning coverage following their pregnancy.

Children ages one through five years are eligible at 133% of the Federal Poverty Level (FPL) without resour through 18 are eligible at 100% of the FPL.

Family Health Plus Medicaid is available at two levels. Adults with children under the age of 21 whose gross 150% of the Federal Poverty Level and single adults with gross family income up to 100% of the Federal Po

Children, ages one month to age 19 years, with family incomes at or below 250% of the FPL, are eligible for coverage under Child Health Plus. Coverage for those under 160% FPL is free. Premium contribution for far $9 per child per month, with a maximum of $27 per family per month. For families with incomes between 22 contribution is $15 per child per month, with a maximum of $45 per family. For families with incomes over 25 Plus is available at full premium. There are no co-payments for services. Table 13 indicates current eligibility

#07 Health Systems Capacity Indicator
The percent of EPSDT-eligible children aged 6 through 9 who have received dental services during the year

It appears that percentages are dropping slightly. We believe this is due to a tightening in the supply of denti (The number of clients across all age groups who receive MA-financed dental services is down, despite fees

In 2002, the percentage was 35.8%; in 2003 the percentage was 35.1%. In 2004, the percentage increased

Program efforts to improve this indicator include:
• Improved oral health surveillance that included third graders in every county of New York State, which was departments and is available on the DOH web;
• Attention to access issues within the Statewide Oral Health Plan;
• Funding of Innovative Dental Services projects, which are testing new and innovative, community-generate issues, and funding of 8 school-based health centers;
• Provision of dental sealants by 23 contractors statewide; and
• Expansion of the dental sealant program and school-based dental centers in 2004.
#08 Health Systems Capacity Indicator
The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Care Needs Program

This indicator is not particularly applicable to New York, since all SSI recipients automatically have Medicaid our Physically Handicapped Children's Program.
NYSDOH continues to fund local county health department-based Children with Special Health Care Needs reimbursement for specialty care through the Physically Handicapped Children's Program.

#09A Health Systems Capacity Indicator
The ability of States to assure that the Maternal and Child Health Program and the Title V agency has acces

relevant information and data

Efforts to improve data access include:
• The SSDI Project initiated development of an infrastructure to improve data linkages.
• During 2004, the SSDI Coordinator assisted the Division of Family Health in expanding the membership of
Information System (ICHIS) Workgroup to include staff from various units within the Department that admini
• MCH data is placed on the HIN (NYSDOH's public website) and on the HPN (NYSDOH's provider health n
Centers also have access. The Title V application is available on the public website, as well.
• SSDI developed a new Request for Applications for MCH consumer focus groups.
• One of the objectives of the Early Childhood Comprehensive Systems initiative is to improve data sharing
• The Medial Home Unit finalized business requirements for the CSHCN Information System. The new syste
information by assisting local programs to report their data in a timely and efficient manner.
• The Champions of Progress initiative will train parent advisors, which will provide additional parent/consum

#09B Health Systems Capacity Indicator
The ability of States to determine the percentage of adolescents in Grades 9 through 12 who report using to
month

This is an item on the YRBS, in which New York participates. Adolescent smoking rates are also available th
Survey. The Division of Chronic Disease Prevention and Adult Health employs an epidemiologist for the tob
both adult and child smoking data. For additional program information, please refer to State Negotiated Perf

#09C Health Systems Capacity Indicator
The ability of States to determine the percent of children who are obese or overweight

Obesity data is available both from the WIC program and from the Youth Risk Behavior Survey. We have nc
We have data from an old study (1996) of New York City School children. As of last year, nutrition/obesity su
incorporated into the ongoing dental surveillance initiative, doing height and weight measurements at the sa
Under the PAN (Physical Activity and Nutrition) Initiative, there will be further discussion on gaps in data gat

Schools that conduct the School Health Index will identify changes needed in the school environments and/
made as a result of this assessment will be supportive of healthy eating and physical activity.

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

A. Background and Overview

This section profiles New York's maternal and child health priorities, selected performance measures, and p
the extent to which National and State objectives were met in this program year.

As previously described, New York has undergone extensive priority-setting processes. Throughout, particip
preferring that each of these "opportunities for improvement" be considered of equal importance. Following t
cycle required by Title V, and in consideration of past progress, several performance targets were re-adjuste
and the specific performance measures related to each, stem specifically from areas of unmet need in the S

New York Title V is using an Oracle-based system for gathering and managing program information that del
sources of funds, staffing and performance measures for the maternal and child health-related programs. Be
year our system has been in use, there may be some discontinuity of the financial data with previous years'
gathered from program managers in all of the MCH-related programs, whether or not the programs are bloc

Most often, programs that address maternal and child health issues initiate services and interventions on a v
addressing access to care, we are improving the insurance and charity care infrastructure, targeting populat
clients to access and sustain their relationship to a medical home, and work to remove barriers to accessing
services. Thus, each of the four levels of the MCH pyramid may be relevant to a particular need.

A brief summary of New York's accomplishments through use of Title V and other funds appears in Section
Federal and State Performance and Outcome Measures are tracked on Forms 11 and 12.

B. STATE PRIORITIES

After the last full Needs Assessment (which is done annually in New York), priority setting was conducted as

• The results of the Communities Working Together and other participative processes;
• The use of the many and various data sets available to the Department;
• The use of program data and provider input to identify trends and issues;
• Infrastructure evaluation;
• The input of the public and the Maternal and Child Health Services Advisory Council to assist in interpretin
important trends, gaps in services or barriers to care; and
• The input of key staff within the Department.

The process remains unchanged since the last application. Collaborations and partnerships that contribute t
process have also remained unchanged.

As a result of the needs assessment process, the following ten priorities were identified:

• To improve access to high-quality health services for all New Yorkers, with a special emphasis on prenatal
preventative care, which includes attention to mental health issues and which serves those with special heal
• To improve oral health, particularly for pregnant women, mothers and children, and among those with low i
• To prevent and reduce the incidence of overweight for infants, children and adolescents;
• To eliminate disparities in health outcomes, especially with regard to low birth weight and infant mortality;
• To improve diagnosis and appropriate treatment of asthma in the maternal and child health population;
• To reduce or eliminate tobacco, alcohol and substance use among children and pregnant women;
• To reduce unintended and adolescent pregnancies;
• To implement new genetics tests within the statewide system of newborn metabolic screening;
• To reduce the rate of violence across all age groups, including inflicted and self-inflicted injuries and suicid
• To improve parent and consumer participation in the Children with Special Health Care Needs Program, as

The justification for their selection as priorities may be found in Section II. B. 1. and a description of our plan be found in Section II. A. This same section also contains a table that summarizes the relationship between the measurement of their progress through Federal and State Performance and Outcome Measures.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) n sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appro their State.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003
Annual Performance Objective				
Annual Indicator	100.0	100.0	100.0	
Numerator	258449	255529	253545	
Denominator	258449	255529	253545	
Is the Data Provisional or Final?				Final
	2005	**2006**	**2007**	**2008**
Annual Performance Objective	100	100	100	

Notes - 2002

2002 data or estimates are not availabe

Notes - 2003

2003 data are not available for this measure.

a. Last Year's Accomplishments

• 250,209 infants were screened for genetic disorders in 2004 by NYSDOH's Wadsworth Laboratories New

• 100% of newborns in NYS are tested for over thirty congenital conditions:
o PKU
o congenital hypothyroidism
o galactosemia
o sickle cell disease
o biotinidase deficiency
o cystic fibrosis
o homocystinuria
o congenital adrenal hyperplasia
o maple syrup urine disease
o medium-chain acyl-Co-A dehydrogenase deficiency
o citrullinemia/arginosuccinic academia
o tyrosinemia
o carnitine uptake deficit
o short-chain acyl-CoA dehydrogenase deficiency
o very long-chain acyl-CoA dehydrogenase deficiency
o carnitine palmitoyltranferase II deficiency/cariniten/acylcarnitine translocase deficiency
o long-chain hydroxyacylacyl-CoA dehdrogenase deficiency
o propionic academia/melhyl malonic academia/multiple carboxylase deficiency
o beta-ketothiolase deficiency
o isovaleric academia
o 3-hydroxy-3-methylgluteryl-CoA lyase deficiency/3-methylcrotonyl-CoA carboxylase deficiency
o glutaric academia type 1

o multiple amino acid disorders
o multiple acylcarnitiens
o multiple amino acids and aclycarnitines and
o exposure to HIV-1.
• Of children screened, there were 5 confirmed cases of PKU, 127 confirmed cases of Congenital Hypothyr
Glactosemia, 129 of Sickle Cell Disease, 2 of Biotinidase Deficiency, 27 cases of Cystic Fibrosis, 16 cases
MSUD or homocystinuria, and 8 cases of MCADD. (See Form 6.) Testing for other conditions began in Nov
• The Newborn Screening Program and the Children with Special Health Care Needs Program approved st
types of Specialty Center standards were produced: Cystic Fibrosis, Endocrine and Inherited Metabolic Dis
• Prenatal Genetics Services were provided to 23,370 people in 2004.
• Another 19,559 individuals received Clinical Genetics Services through Title V genetics services grantees

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	D
1. 250,209 infants were screened in 2004.	
2. 100% of infants with abnormal findings were followed up. 100% received treatment.	
3. Wadsworth Laboratories expanded their capacity to provide additional metabolic testing.	
4. The Newborn Screening Program and the CSHCN Program collaborated on approval of standards for Cystic Fibrosis, Endocrine and IMD Specialty Centers.	
5. Specialty Centers were approved under the new standards.	
6. Prenatal Genetics Services were provided to 23, 370 people in 2004.	
7. Local Health Departments assisted in locating and getting infants to needed follow-up care.	
8. Wadsworth Center administered 23 contracts for Clinical Genetics Services.	
9.	
10.	

b. Current Activities

• Wadworth Laboratories continues to screen 100% of the state's newborns for the conditions listed above.
positive screens are followed for confirmation; 100% of confirmed cases are followed to ensure treatment.
• Title V continues to monitor follow-up on active cases to ensure that infants with positive results receive a
• Local health units continue to use Article 6 State Aid reimbursement to pay for follow-up visits by public he
insurance companies for these services.
• Clinical genetics services, including follow-up genetics counseling for families of children with inborn meta
through the Genetics Program. The Wadsworth Center for Laboratories and Research administers 23 contr
• Comprehensive Prenatal/Perinatal Services Networks promote newborn screening and appropriate follow
and provider meetings.

c. Plan for the Coming Year

• Newborn Metabolic Screening will continue.
• The CSHCN and the Genetics Screening Programs will continue to monitor implementation and ensure a
services.
• The CSHCN and Newborn Screening Program will continue joint monitoring visits to Cystic Fibrosis, Endo
Metabolic Diseases Specialty Centers.
• There are no plans for further changes at this time.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whos making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003
Annual Performance Objective				
Annual Indicator			60.3	
Numerator				
Denominator				
Is the Data Provisional or Final?				Provis
	2005	**2006**	**2007**	**2008**
Annual Performance Objective	62	64	66	

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

Last Year's Accomplishments

• The CSHCN Program continued to employ a Family Specialist, the parent of a child with special health ca other employees

• The CSHCN Program continued to broaden in areas of policy development, improving access to health ar CSHCN, identifying and referring CSHCN to appropriate services, and collecting information to identify gap improve the system of care for CSHCN.

• Parents were invited and participated in consumer focus groups held around the State. Parents participati their time, travel and child care expenses. Focus groups were held to engage groups most at risk for poor h obtain information on their health care needs. The information from the focus groups will help to improve th women, infants, children and youth in New York State, including those with special needs. These groups we initiated by the SSDI Coordinator and the Title V Coordinator.

• Parents of CSHCN spoke at public hearings sponsored by the MCHSBG Advisory Council.

• Healthy Start consumers met with Title V staff to discuss consumer involvement. This group gave Title V s consumer focus group methodology. The project received very favorable reviews.

• The NYS Medical Home Project began training local CSHCN programs in medical home concepts and be programs include in their annual workplans enhanced parent involvement.

• Family Specialist participated as a member of the state team at the national EMSC conference. The Famil family and EMS providers about how to be prepared for an emergency that involves a child with special nee representative, the Family Specialist represented families of CSHCN at meetings and conferences of regio

• NYSDOH won a Champions of Progress grant.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	D
1. SSDI and Title V conducted consumer focus groups to obtain information directly from parents about their experiences with health services. Parents also spoke at Public Hearings held by the MCHSBG Advisory Council.	

2. The CSHCN Program provided information, referral, care coordination and financial assistance to families of children with special needs through contracts with local health departments and community-based organizations.
3. CSHCN employs a Family Specialist.
4. CSHCN Program was granted funding under Champions for Progress. Selection of Family Champions was completed and training begins in July 05.
5. The Medical Home Project trained local CSHCN Programs in medical home concepts.
6. Healthy Start consumers provided feedback to the Family and Consumer Focus Groups and serve in an advisory capacity to the project.
7. Parent involvement scores improved in 2004!
8.
9.
10.

b. Current Activities

Current Activities -- There were no major changes in programming.
• CSHCN Program staff continues to work with the parent involvement strategic plan formulated in 1999 to i into MCH programs and policy development.
• CSHCN Program staff are working with other MCH programs and stakeholders to plan training for Parent
• CSHCN Program staff and the Title V Coordinator is working with the SSDI Coordinator to implement pare groups.
• The CSHCN Program has begun provider training in medical home concepts.
• CSHCN Program staff and the Title V Coordinator is working with the SSDI Coordinator to facilitate a mee consumer representatives who were invited to critique our focus groups methodology.
• The Early Intervention Program offers leadership training programs, informational bulletins, and parent me practice consensus panels. There is an active Parent Involvement Committee.
• The Early Intervention Program employs a Family Initiatives Coordinator, who is the parent of a child with a range of parent initiatives.
• Parent involvement scores improved in 2004.

c. Plan for the Coming Year

Plan for the Coming Year
• Further examine SLAITS data. We are considering publishing fact sheets on the various measures.
• Repeat focus groups.
• Continue implementation of the NYS Medical Home Project and improving parent involvement.
• Continue funding local health departments to assist CSHCN and their families.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receiv comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003
Annual Performance Objective				
Annual Indicator			51.7	
Numerator				
Denominator				

Is the Data Provisional or Final?				Final
	2005	**2006**	**2007**	**2008**
Annual Performance Objective	52	55	58	

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

• The Children With Special Health Care Needs (CSHCN) Program implemented Year 2 of NYS Medical Ho HRSA. The grant is a collaborative activity of families of CSHCN, NYSDOH, District II of the American Acad American Academy of Family Physicians and other key stakeholders. The goal is to develop and implemen home plan for New York State and to ensure all NYS CSHCN have access to medical homes. The NYS Me trained local CSHCN Programs in medical home and parent involvement concepts.
• The CSHCN Program funded local county health departments to provide health information and referral to families, so that they may assist families with obtaining health insurance coverage, finding a medical home, specialty care and other needed services.
• In 2003, there were 5,233 children served by the CSHCN Program. Fifty-four percent (54%) of children we primary care provider, up from 51% in the previous year. The CSHCN Program is using the presence of a p one component for the measure of a medical home.
• In 2004, there were 5,498 children served by the CSHCN Program. Sixty-six percent of children enrolled i primary care provider. CSHCN Program staff assisted families in locating a primary care provider who parti plan. This is a twelve percent increase over the previous year in the number of children who were reported provider.
• Staff of the Medical Home Unit actively promoted the concept of medical home through informational sess groups of physicians, families, and allied health professionals. Physician groups included the Graduate Med program staff and the Pediatric Advisory Group for the New York State Department of Health Office of Man meetings were held with all contractors of the Children with Special Health Care Needs Program.
• A Grand Rounds session was held with a new HRSA Medical Home grantee, St. Charles Hospital, to assi disseminate information about medical home to attending physicians, residents, allied health professionals,
• The CSHCN Program worked with the New York State Technology Enterprise Corporation (NYSTEC) to f requirements for the CSHCN Information System. This system will provide relevant program data and make programs to track the CSHCN treatment experience.
• In 2004, there were 320 children who received a diagnostic evaluation under the Physically Handicapped (PHCP). This program assists families who are underinsured to obtain a diagnostic evaluation for their child specialty providers for their services. Additionally, 837 children were served through the PHCP Treatment F based upon 24/58 local PHCPs reports

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**D**
1. The Medical Home Unit and CSHCN Program implemented the Medical Home Project funded by HRSA collaboratively with families, District II AAP, and the American Academy of Family Practitioners.	
2. The Medical Home Project provided training in medical home and parent involvement concepts.	
3. The CSHCN Program funded local CSHCN programs to provide health information and referral to families and to assist families in obtaining health insurance, a medical home, and link with specialty care and other needed services.	

4. Over 5,000 children were directly served by local CSHCN Programs, enabling them to obtain needed care and services.
5. The NYS Physically Handicapped Children's Program provided direct financial assistance to 387 children for treatment services not covered by Medicaid and other insurances. (Incomplete data.) 320 children received diagnostic and evaluation services
6. NYSDOH staff participated in NICHQ Medical Home Learning Collaborative.
7. The Early Intervention Program had an active Medical Home Workgroup and continued to ensure that children served by EI have a medical home.
8. The Growing Up Healthy Hotline provided referral to primary and specialty services.
9. Healthy Children New York trained Child Health Promotion Specialists to assist child care settings in helping families find medical homes.
10. The School Health Program provided medical homes for children from high needs areas who would not otherwise have access to care.

b. Current Activities

• No major changes were made.
• NYS Title V staff have examined SLAITS data from NYS and include these data in all presentations for the Staff query the Data Resource Center for Child and Adolescent Health/Child and Adolescent Health Measu base.
• Medical Home outreach activities continue. The concept is included in Champions training.
• The Early Intervention Program has an active Medical Home Workgroup to ensure children in their progra medical homes.
• CSHCN Program staff continue to assist families without medical homes to find medical homes for their ch
• Title V staff participate in NICHQ Medical Home Learning Collaborative (MHLC) including attendance at a and site visits to all NYS MHLC participating practices.
• Local health department programs actively link lead poisoned children with special health care needs to th available in the communities. In most cases, a lead poisoned case automatically given an developmental sc to local Early Intervention (EI) program to ensure care coordination.
• Discussions and informational sessions have been held with the Early Intervention Program and the Deve Planning Council.
• The Early Intervention Program had an active Medical Home Workgroup to ensure children in their progra medical homes.
• The American Indian Health Program and the Migrant Health Program both worked to improve access to c to establish a medical home for children. Because of the unique circumstances of migrant children, provide connectivity with upstream and downstream providers.
• The Growing Up Healthy Hotline continued to provide information to callers about access to medical home
• The School Health Program located 192 school-based health centers in areas where morbidity and mortal mental health conditions were disproportionately high. School-based health centers in NY are required to pr hours per day, seven days per week.
• All New York State Department of Health Programs dealing with prenatal care (PCAP, MOMS, Community with expectant parents to help find a provider for their baby.
• Healthy Children New York Child Health Promotion Specialists assisted families in child care and other ch locate and enroll in a medical home.

c. Plan for the Coming Year

• Continue implementation of the NYS Medical Home Improvement Project. Community medical home infor providers and families are being planned with one team who attended the National Initiative for Child Health Collaborative sessions.
• Continue to engage key stakeholders in development and implementation of a statewide medical home pl regional trainings will be offered.
• The Bureau of Child and Adolescent Health will continue to engage a diverse stakeholder group to advise identification, recruitment, and training of family advisors (a.k.a. Family Champions) to the Title V Program.

includes representatives from the Department of Health and other state agencies (Office of Mental Health, O Retardation and Developmental Disabilities, Developmental Disabilities Planning Council), family organizati Family Voices, Families Together, and Parent Training and Information Centers). Family Champions will be additional training, and engaged in CSHCN Program activities.
• Continue funding local health departments to provide CSHCN Program services.
• The CSHCN Program will continue to work with contractors who serve CSHCN to refer children without a health care providers and sources of insurance to access health care providers.
• The CSHCN Program will encourage local CSHCN Programs to become aware of the medical home conc parent involvement are now required workplan elements.
• The Physically Handicapped Children's Program will continue to provide reimbursement for diagnostic and those eligible children who are underinsured.
• Continue analysis of SLAITS. Use as benchmarking.
• Continue Medical Home Workgroup under the Early Intervention Program.
• Increase number of child care health consultants who can assist children to obtain medical home.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose fam and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**
Annual Performance Objective				
Annual Indicator			59.1	
Numerator				
Denominator				
Is the Data Provisional or Final?				
	2005	**2006**	**2007**	**2008**
Annual Performance Objective	70	75	80	

Notes - 2002
The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003
The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004
The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

• The CSHCN Program continued to fund local county health departments to provide health information and their families, to assist families with obtaining health insurance coverage, finding a medical home, or linking other services.
• The Physically Handicapped Children's Program under the NYS Children with Special Health Care Needs provide gap-filling coverage for children with special health care needs birth to age 21 for services that insu for children in special financial circumstances who are ineligible for Medicaid or Child Health Plus.
• In 2004, there were 320 children who received a diagnostic evaluation under the Physically Handicapped (PHCP). This program assisted families who were underinsured to obtain a diagnostic evaluation for their c specialty providers for their services. Additionally, 837 children were served through the PHCP Treatment F based upon 24/58 local PHCPs reporting at the time of this submission.
• Each county within NYS had enrollment sites where families could be assisted to gain access to public ins enrollment forms. Each local health department CSHCN Program was required to have a referral linkage to

enrollment agency in their area. In some cases, the facilitated enrollment program is within the same agenc
• NY uses a combined Medicaid, Food Stamps, Child Health Plus, Family Health Plus and WIC enrollment
• All children identified as uninsured and underinsured by the Childhood Lead Poisoning Prevention Progra
appropriate local public insurance enrollment source. Lead poisoned children and their families, without hea
directed to and assisted with enrollment in MA and/or Child Health Plus to expedite access to care. State pr
technical assistance to local program to expedite enrollment. Systems were in place to help uninsured need
attention.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	D
1. The CSCHN Program funded local agencies to provide assistance to families in obtaining health insurance coverage and a medical home.	
2. The Physically Handicapped Children's Program provided gap-filling coverage for children under age 21 that insurances will not cover or whose financial circumstances make them ineligible for Medicaid.	
3. Each county in New York has enrollment sites where families can be assisted to gain access to public insurance programs, Food Stamps, and WIC.	
4. New York uses a combined enrollment process for Medicaid, Child Health Plus, Food Stamps and Medicaid.	
5. Each local CSCHN Project is contractually required to have a referral relationship or provide facilitation with enrollment in public insurances.	
6.	
7.	
8.	
9.	
10.	

b. Current Activities

Current Activities
• Same as above

c. Plan for the Coming Year

Plan for the Coming Year
• The CSHCN Program will continue to fund local health departments to work with CSHCN and their familie
health insurance and medical homes.
• The Physically Handicapped Children's Program will continue to provide reimbursement for diagnostic and
those eligible children who are underinsured.
• No major changes are planned with regard to Medicaid or Child Health Plus coverage.
• Local programs will continue to link with facilitated enrollers.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures *[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]*				

Annual Objective and Performance Data	2000	2001	2002	2003
Annual Performance Objective				
Annual Indicator			75.3	
Numerator				
Denominator				
Is the Data Provisional or Final?				Final
	2005	**2006**	**2007**	**2008**
Annual Performance Objective	78	80	82	

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

• The CSHCN Program continued to fund local county health departments to provide health information and their families to assist families with obtaining health insurance coverage, finding a medical home, or linking other services.
• The CSHCN Program, under authority of the Physically Handicapped Children's Program legislation, had approve Specialty Centers. Specialty Centers are expected to provide family-centered, comprehensive, cult appropriate care. They are also expected to work in a coordinated fashion with the child's community-based
• The Early Intervention Program continued to be funded by State and other Federal appropriations, but it k MCHSBG programs and services, providing direct services to infants and young children who were identifie risk for disabilities. The child find mechanism under EI located and tracked developmental surveillance of at families and linked families with appropriate services. EI was/is a major source of MCH referrals.
• The Early Intervention Program employed two types of service coordination. The first type assisted familie phase of entry into the Early Intervention Program, helping them to deal with the multi-disciplinary evaluatio the first Individualized Family Services Plan. The second type of service coordination was ongoing, designe are supported through all aspects of the Early Intervention Program and that EI services are coordinated wi supports offered to families for sources outside of the program.
• The Community Health Worker Program assisted families to connect to health care services and sustain t
• Consumer focus groups were asked about their experiences with accessing services. This information wa managers and policy makers to ensure incorporation into program planning.
• The Resource Directory for Children with Special Health Care Needs was reprinted and distributed to loca hospitals, community agencies, schools, libraries, families and other providers. The directory was/is availab Russian, Chinese and French.
• The Congenital Malformations Registry staff sent informational mailings to notify families of children born v Early Intervention Program and support groups available statewide.
• Local health department programs actively link lead poisoned children with special health
care needs to the appropriate services, if available in the communities. In most cases, a lead poisoned chil given a developmental screening and/or referred to local Early Intervention (EI) program to ensure care coo

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	D
1. The CSHCN Program continues to fund local programs to provide information to families to assist	

them in using community-based and specialty services.	
2. The CSHCN Program has authority to approve Specialty Centers, which are expected to be family-centered, compehensive, community-based, and culturally competent. The CSHCN Program monitors specialty centers for compliance.	
3. The Early Intervention (EI) Program requires that at-risk infants and their families be tracked and assisted to access needed services.	
4. The EI Program employs 2 types of services coordination: 1. Assisting families through the initial entry into services and 2. helping families deal with multidisciplinary evaluation and formation of the IFSP (Individualized Family Services Plan).	
5. The Medical Home Project is impacting the "family friendliness" of local systems of care through training and technical assistance.	
6. Family Champions are being trained.	
7.	
8.	
9.	
10.	

b. Current Activities

Current Activities

• The Medical Home Project is being organized to have an impact on the "family friendliness" of local syster
• Local health department CSHCN Coordinators work with families and providers to enable smooth referrals and other needed services.
• The Early Intervention Program continues to provide initial and ongoing service coordination.
• SLAITS data was received and is undergoing more analysis with the aid of the CDC.
• Results of consumer focus groups are being shared with all MCH and public insurance programs.
• The Early Intervention Program continues to work with the Children with Special Health Care Needs Progr issues, such as parent involvement and sharing of data.
• Training of Family Champions is currently taking place. Family Champions will receive full orientation to th NYSDOH MCH programs.

c. Plan for the Coming Year

• The CSHCN Program will continue to fund local health departments to work with CSHCN and their familie health insurance and medical homes.
• The CSHCN Program will continue to work with the providers of specialty care to ensure ease of referral *a*

• EI service coordination will continue.
• Continue implementation of the Medical Home Project.
• Continue Medical Home Training for providers.
• Continue to monitor Specialty Centers for adherence to program standards.
• Continue to make this a topic for the MCH consumer focus groups.

Performance Measure 06: *The percentage of youth with special health care needs who received the serv transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003

Annual Performance Objective				
Annual Indicator			5.8	
Numerator				
Denominator				
Is the Data Provisional or Final?				Final
	2005	**2006**	**2007**	**2008**
Annual Performance Objective	7	9	11	

Notes - 2002

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator except for Maine which has its State value noted.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

a. Last Year's Accomplishments

Last Year's Accomplishments

• The CSHCN Program sent out materials to children enrolled in the program who have reached transitiona explained the need for transition planning and gave key points to consider.
• Transition activities were required for inclusion in the local CSHCN workplans.
• In 2004, the Physically Handicapped Children's Program served 918 children under the Diagnostic and Ev 3288 children under the Treatment Program. These numbers reflect 56 of the 58 counties who reported dat

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**D**
1. Materials were sent out by the CSHCN Program to children in the program reaching transitional age. Material explain the need for transition planning and give key points to consider.	
2. Transition activities are required in the contractual workplan of all CSHCN local providers..	
3. CSHCN Program staff monitor the performance of local programs on transition issues.	
4. CSHCN staff provide training and technical assistance to local programs on transition issues.	
5. Training was provided to CSHCN parents.	
6. CSHCN Program staff work with State Education and Labor Department staff on issues related to transitioning from school to work.	
7.	
8.	
9.	
10.	

b. Current Activities

Current Activities -- Activities listed above continue.

• CSHCN Program staff continues to work with the State Education Department and the State Department issues.
• CSHCN Program staff monitor and provide technical assistance to local programs around transition issue
• Title V staff continue to utilize SLAITS data in understanding the status of this issue for NYS.

• Staff spoke to 50 parents regarding transition of youth and importance to families.
• The Family Specialist, as part of a subcommittee of the Children's Issues Committee of New York State's Disabilities Planning Council, helped develop a Request for Proposals (RFP) for the creation of a web-base The curriculum would be to assist developmentally disabled individuals ages 14 to 25, their families and pro The RFP will be considered for approval in September 2005.

c. Plan for the Coming Year

Plan for the Coming Year - No major changes planned.
• DOH will continue to work with the State Education Department and the State Department of Labor on tra
• CSHCN staff will continue to monitor the performance of local programs on issues related to transition.
• CSHCN staff will continue to work on information systems development that will assist the program to trac
• New SLAITS data will be analyzed for progress. Data will be used for benchmarking.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appro Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003
Annual Performance Objective	78	75	77	
Annual Indicator	75.2	74.8	75.3	
Numerator				
Denominator				
Is the Data Provisional or Final?				Final
	2005	**2006**	**2007**	**2008**
Annual Performance Objective	85	86	87	

Notes - 2002
numerator and denominator are not available for this indicator. (survey data)

Notes - 2003
Numerator and Denominator are not available for this measure (survey data). Data year is from 7/2002 - 6/

Notes - 2004
Data is from the National Immunization Survey. Numerator and Denominator data are not available. Data is 7/03-6/04.

a. Last Year's Accomplishments

•The Immunization Program provided vaccines through the NYS Vaccines for Children Program, assessed worked to improve them, provided technical assistance to providers, disseminated educational materials, a departments with disease surveillance and outbreak control activities, and continued to develop a statewide CDC categorical grants and State and Local Assistance dollars were used to provide staffing in both centra to purchase vaccines. County health departments assisted in recruiting VFC providers.
•Over 90% of two year-old children in New York State (outside New York City) were/are vaccinated in priva public clinics. Under the Provider-Based Immunization Initiative (PBII), county staff visited pediatricians and records of their patients for compliance with immunization and lead screening schedules. The information w computer using CDC-developed software, the Clinical Assessment Software Application, (CASA). CASA ca immunization rate and enabled them to improve their vaccination protocols, when necessary.
Last Year's Accomplishments -- continued
•Comprehensive Prenatal/Perinatal Services Networks provided education and outreach to engage childrer

system. Some networks conducted outreach for Child Health Plus and to ensure that parents were aware o
comprehensive immunization.
•Risk-reduction home visits were made to the homes of lead affected children.
•Early Intervention Program service coordinators also checked that children received appropriate primary ca
•The Lead Program has strong programmatic links to the Immunization program via VFC and PBII. Immuniz
screening records are reviewed, in many instances by SDOH and/or local health department staff. This help
provider awareness and compliance.
•Welcome to Parenthood, a packet that was given to the family of each newborn born in New York, contains
childhood immunizations.
•Article 6 State Aid to Localities reimbursed local health departments for the infrastructure that supported im
tracking, parent and provider education and special studies.
•Up-to-date immunizations were provided to the 1800 children in migrant day care settings.
•The Community Health Worker Program educated parents about immunization, assessed the immunizatio
the program, referred and assisted families to obtain immunization, and followed-up with families to assure
the service. In 2003, 82% of the children entering the program were fully immunized. Of those who were no
received needed immunizations after they came into the program and an additional 40% were pending. A to
completely immunized.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	D
1. New York State Vaccines for Children Program assesses immunization rates and works to improve them.	
2. The Physican Based Immunization Initiative has DOH staff visiting private doctors' offices to assess medical records and provide assistance with identifying missed opportunities for vaccination.	
3. Early Intervention Program providers check immunization status of enrolled children, as does WIC, the Childhood Lead Program, PCAP, the Community Health Worker Program and others.	
4. The Welcome to Parenthood booklet was given to the family of each newborn born in NY. It contains information on childhood immunization.	
5. Local health departments are eligible for State Aid for immunization related activities.	
6. Healthy Children New York included in the training on increasing immunization compliance in child care.	
7.	
8.	
9.	
10.	

b. Current Activities

Current Activities -- Same as above. Activities continued, plus:
• PCAP and MOMS also educated parents in the need for preventive services, including immunization.
• Immunization records were reviewed and children were referred or provided with immunizations and for le
clinic visits for WIC.
• CISS grant activities under Healthy Child Care New York included discussion of immunization requiremen
training program for Child Care Health Consultants. Child care health consultants assisted child care provid
thereby increase verified rates of immunization and lead testing. Child care providers referred children lacki
their provider.

c. Plan for the Coming Year

Plan for the Coming Year -- No major changes are planned.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003
Annual Performance Objective	18.5	17.3	16	
Annual Indicator	18.7	16.1	15.7	
Numerator	6952	5996	5867	
Denominator	371698	372422	374080	
Is the Data Provisional or Final?				Provis
	2005	**2006**	**2007**	**2008**
Annual Performance Objective	13	12	11	

Notes - 2002
2002 data corrected on 6/2005

Notes - 2003
2003 data are not available.

Notes - 2004
2003 data are being used as a proxy for 2004.

a. Last Year's Accomplishments

• The Family Planning Programs provided community education, comprehensive reproductive health care, a
contraceptive methods, counseling and testing for HIV, and screening and treatment for sexually transmitte
family planning programs provided services to 341,532 individuals in 2003, and 28% were under the age of
• The Community-Based Adolescent Pregnancy Prevention Program's goal was/is to reduce teen pregnanc
codes (now 54 statewide) across New York State. C-BAPPP promoted abstinence and the delay of sexual
encouraged educational, recreational and vocational opportunities as alternatives to sexual activity; taught
promoted access to family planning and comprehensive reproductive health services.
• NYSDOH Bureau of Child and Adolescent Health funded 37 Abstinence Education and Promotion contrac
abstinence education, mentoring, counseling, and adult supervision to promote abstinence from sexual acti
They focused on junior high/middle school aged students. The Not Me, Not Now campaign will continue as
media campaign to support the community-based initiatives.
• The Comprehensive Prenatal/Perinatal Services Networks promoted reduction of adolescent pregnancy ra
and community conferences, outreach and education efforts. The Networks conducted education and outre
the reproductive health of all women, including teens.
• Article 6 reimbursed local health departments with State Aid for health education and other population-bas
supported infrastructure needed to provide data collection, data evaluation, community-based planning and
collaborative intervention strategies.
• The Rape Crisis Program developed and implemented policies designed to provide effective and compass
sexual assault and supported professional and community-based prevention education programs.
• The Comprehensive Prenatal/Perinatal Services Networks conducted education and outreach activities to
reproductive health of all women, including teens.
• Risk assessment for sexual activity was a part of the initial assessment and anticipatory guidance offered
Centers. Pregnancy testing was done when indicated. Students had access to family planning services, eith
Students were also referred early for prenatal services; practitioners co-manage the students' prenatal care
centers provided services to approximately 35,000 female students, ages 15 to 19 years.
• ACT for Youth continued its youth development focus, building assets for resiliency and resourcefulness a

Centers for Excellence provided information statewide and in various conferences on Youth Development c
practices.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	D
1. Family Planning Programs provided care to over 340,000 individuals.	
2. Family Planning Programs provide community education, comprehensive reproductive health care, a ful range of contraceptive methods, counseling and testing for HIV, and screening and treatment for STDs.	
3. The Community-Based Adolescent Pregnancy Prevention Program's (C-BAPP) goal is to reduce teen pregnancy in the highest risk zip codes in the state through a Youth Development Model.	
4. 37 Abstinence Education Programs promote abstinence from sexual activity through a variety of Youth Development activities aimed at junior high school students.	
5. Comprehensive Prenatal/Perinatal Services Networks work in areas of the state at high risk for poor pregnancy outcomes to reduce teen pregnancy through community education and outreach.	
6. The Rape Crisis Program provides Emergency Contraception and compassionate treatment of victims of sexual assault.	
7. Risk assessment for sexual activity is a part of every school-based health center history and physical. Risk reduction guidance and referrals are offered.	
8. ACT for Youth continued its focus on Youth Development, building assets for resourcefulness and resiliency among youth.	
9. ACT for Youth Centers for Excellence provided information statewide and at various conferences on Youth Development concepts and best practices.	
10. Large scale media campaigns play during hours of prime teen viewing and on stations watched by teens.	

b. Current Activities

There were no major changes in activities this year. In addition to activities above, the following also occurr
• The Department met with Healthy Start grantees in order to enhance communication and coordination am
V.

c. Plan for the Coming Year

No major changes are planned.
• New grantees will receive technical assistance, if necessary.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at le*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003
Annual Performance Objective	29.4	31.5	40	
Annual Indicator	25.3	25.3	57.5	
Numerator			1791	

Denominator			3115	
Is the Data Provisional or Final?				Final
	2005	**2006**	**2007**	**2008**
Annual Performance Objective	40	50	60	

Notes - 2003

NYS survey of 10,369 students from 272 schools.

Notes - 2004

333333

a. Last Year's Accomplishments

•The Bureau of Dental Health completed dental surveillance in each county. The surveillance grant was act enrolling children for oral health screening and referring children to dental care.
•24 of the 26 School-Based Preventive Dentistry Programs continued to place sealants in 2004, serving 30, providing 9,929 referrals. This program targeted school children in grades 2, 3, 7, and 8 in low socioeconon children with a point of entry into the dental care system. Students were screened for adverse dental condit application of sealants. Sealant sites increased participation in their program each year. Children who need services were referred. All families in targeted school districts received promotional and educational informa contribute to the program's success.
• Beginning in 1999 and continuing to the present, the Preventive Dentistry Program entered into communit parents, consumers, providers and public agencies for identifying and addressing community problems rela community-based problem solving approach has help to identify effective interventions to suit community n
• Funding for school-based sealant programs was increased by $1M in 2003-2004.
• Other dental programs also promoted the use of sealants, including the Preventive Dentistry Fluoride Sup provided over 125,000 children with fluoride supplementation in non-fluoridated areas through schools, day programs.
• The Bureau of Dental Health funded seven projects for Innovative Dental Services to Underserved Areas. Technical Assistance Center was funded at the Rochester Primary Care Network. The TAC Director, Dr. Bu demonstrated success with building community-based organizations responsive to children's dental needs, developing projects.
• The Bureau of Dental Health convened a workgroup to formulate the state's Oral Health Plan. All key stak Dr. Thomas Curran, an oral-maxillary surgeon who is also a member of the Maternal and Child Health Serv Advisory Council has been appointed to that committee. The draft plan recognized school-based dental sea effective population-based strategy to improve the oral health of children.
• The Bureau of Dental Health implemented a listserv and an Oral Health Coalition.
• Article 6 State Aid provided funding for dental health education to each county in New York.
• The American Indian Health Program offered dental services to approximately 2000 children under age 20 reservation referrals. The children's fluoride program was on-going for Pre-K through Grade 6 and monitore dental caries found.
• Dental services were given to approx. 3500 migrant children.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**D**
1. Twenty-four School-Based Preventive Dentistry Program contractors provided dental sealants to over 15,000 children.	
2. Preventive Dentistry Program contractors target school children in grades 2, 3, 7 and 8 in high need, low socioeconmic level areas of the state and provided children with a point of entry to dental care.	
3. All families in targeted school districts receive promotional and educational materials about dental sealants.	

4. Dental sealants are promoted by the Supplemental Fluoride Program, which provide fluoride supplements to over 125,000 preschool and school-aged children in areas of the state that are fluoride deficient.
5. Funding for dental sealants was increased by $1M in the 2003-2004 program year.
6. Seven new Innovative Dental Services Program provders were funded to address problems with dental access in their communities with new and innovative, community-generated activities. Under this initiative, several new school-based dental centers wer
7. Also under the Innovative Services Program, a Statewide Oral Health Technical Assistance Center was funded. The TAC has demonstrated success in building community-based coalitions responsive to children's dental needs.
8. The new New York State Oral Health Plan calls for increasing access to children's preventive services, including dental sealants, through school-based initiatives.
9. 35 new school-based dental health centers were opened in the last program year.
10. Community education on oral health and pregnancy is a required workplan activity for newly procured Comprehensive Prenatal/Perinatal Services Networks.

b. Current Activities

• The Preventive Dentistry Program providers have continued to establish community partnerships involving providers and other organizations for identifying and addressing problems within their communities. This foc effective interventions to suite community needs.
• The Bureau of Dental Health continues work with a wide range of stakeholders on the implementation of t Plan. A series of regional kick-off meetings are being planned.
• Ongoing oral health screening and referral is available to all School Based Health Center (SBHC) enrollee Program provides funding for school-based health centers to establish and enhance dental services for chil by SBHCs, exhibiting substantial risk for dental health problems. Eight providers with thirty-one school-base serving 34,000 students will provide a range of services including education and outreach, screening, referr treatment for students in these schools. Sites will be staffed with a combination of dental assistants, dental Dental students and residents may also be part of the programs to provide them with professional developn help expand these services.
• Community education on oral health is a required component of Comprehensive Prenatal/Perinatal Netwo
• The Department. Based on an agreement with the State Education Department, established 35 new Scho sites.
• 40,000 children were screened and followed by the Preventive Dentistry providers in 28 communities. App children received a total of 18,000 sealants.

c. Plan for the Coming Year

Plan for the Coming Year -- No major changes are planned.
• Re-bid Preventive Dentistry Programs via Request for Applications.
• Expansion of Innovative Dental Services grants to new grantees.
• Continue surveillance activities that were started in the past fiscal year.
• Promote use of Dental Surveillance data.
• Implementation of a Statewide Oral Health Plan.
• Monitor provider billing efforts and their efforts to obtain other sources of funding such as grants, donation etc.
• Continue to promote the use of effective preventive services such as community-based fluoride, dental se other innovative programs.
• Ongoing oral health screening and referral will be available to all SBHC enrollees.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor ve children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003
Annual Performance Objective	0.7	0.6	0.6	
Annual Indicator	0.7	0.8	1.0	
Numerator	29	31	38	
Denominator	3923707	3923707	3846325	
Is the Data Provisional or Final?				Provis
	2005	**2006**	**2007**	**2008**
Annual Performance Objective	0.5	0.5	0.4	

Notes - 2002

2002 is unavailable.

Notes - 2003

2003 data are not available for this measure.

Notes - 2004

2003 data are being used as a proxy for 2004.

a. Last Year's Accomplishments

• Childhood Injury Prevention Projects built successful coalitions for injury control at the local level, reaching segments of the community to ensure that the populace was well informed on issues related to childhood in
• The Injury Prevention Program performed traffic related research and conducts surveillance of passenger brain injury in NYS. The Bureau of Injury Control also represented the Department on the Governor's Traffic
• The Emergency Medical Services for Children Project compiled data to assist providers in prevention activ enhancing the pediatric trauma care system. Motor vehicle crashes annually accounted for about 20.7% of cases and were the largest percentage, of all pediatric Dead On Arrivals (about 35%).
• The Community Health Worker, PCAP and MOMS Programs all had/have extensive child safety compone seat use and other infant safety measures:
• Parents who enrolled with Community Health Workers were given extensive information about childhood s assessed for hazards and workers role model positive parenting skills.
• American Indian Nations with Community Health Worker Programs all had formalized car seat education reservation clinics promoted vehicle safety during individual health education/risk reduction encounters. Las accident helped rally the tribal members to address alcohol/substance abuse, vehicle safety and risk reduct
• PCAP and MOMS had/have an extensive health education agenda, including infant and child safety, use prevention and other causes of infant injuries.
• All school-based health centers provided psychosocial and health risk assessment beginning with the initi family education about safety issues and abuse are included.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	D
1. Continued to collaborate with the Injury Prevention Program and state and local injury control coalitions.	
2. Continued to include child safety programming in all Title V and Title V-related programming for pregnant and parenting women, infants and children	
3. Injury Control Program continued to perform traffic-related surveillance and research.	
4. Continue to support carseat saftey programs within the American Indian Health and Community	

Health Worker Program	
5.	
6.	
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10.	

b. Current Activities

Current Activities - No major changes occurred.

c. Plan for the Coming Year

Plan for the Coming Year - No major changes are planned.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003
Annual Performance Objective	70	72	74	
Annual Indicator	70.4	69.4	72.1	
Numerator				
Denominator				
Is the Data Provisional or Final?				Provis
	2005	**2006**	**2007**	**2008**
Annual Performance Objective	80	82	84	

Notes - 2002

These data are from the Prams Survey. The latest data available is for the year 2000.

Notes - 2003

Numerator and Denominator data are not available for this measure (survey data).

2002 data are being used as a proxy for 2003 and 2004.

Notes - 2004

2003 data are being used as a proxy for 2004.

a. Last Year's Accomplishments

• State regulation continued to require each hospital to have a lactation consultant. Regulations specifically of anti-lactation drugs by standing order and the issuance of sample packs of formula without prescription.
• The Department of Health continued to support the New York State Institute for Human Lactation to increa initiation and continuation rate and provided continuing education on breastfeeding to physicians, midwives care providers, by helping them to promote and manage breastfeeding effectively. The Institute produces a videoconference called the Breastfeeding Grand Rounds that addressed both clinical and public health issu breastfeeding and lactation. The conference, which is broadcast statewide to an audience of approximately annually, included a clinical lecture, a public health lecture, discussion of case studies, and extensive oppor participation and questions.

• For over 25 years, the WIC Program has been effective in reducing the incidence and prevalence of nutrit
pregnancy, infancy and early childhood, specifically low birth weight, infant mortality and iron deficiency ane
Program supported a service delivery system of 100 local agencies, 570 delivery sites, 4300 retail food ven
participants. Breastfeeding promotion and support activities were expanded into all local WIC agencies. The
among WIC participants was 64.1%.
• It is important to initiate discussion about infant feeding choices prior to the antenatal hospital admission. I
encouraged breastfeeding through education during prenatal care and at the postpartum visit.
• The CHWP recognized the benefits of breastfeeding for the infant and mother. To promote breastfeeding,
support and referrals for services. Home visits were conducted shortly after birth with ongoing visits, as nec
of the women in CHWP were breastfeeding at discharge from the hospital and 47.1% of them continued to
six weeks postpartum.
• The Comprehensive Prenatal/Perinatal Services Networks developed and implemented workshops on the
breastfeeding. Part of this strategy in several areas of the State was/is to work with obstetrical nurses and h
encourage and support breastfeeding. Based on the work of the Networks, some hospitals have developed
groups as a mechanism to provide ongoing support to breastfeeding women.
• The Bureau of Women's Health also responded to inquiries about the Department's K through 12 breastfe
materials. There were developed a few years ago and posted on the DOH website
(http://www.health.state.ny.us/nysdoh/b_feed/index.htm).
• The Bureau also conducted periodic hospital surveys to monitor breastfeeding rates.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	D
1. Conducted periodic hospital surveys to monitor breastfeeding rates and compliance with state regulations that support breastfeeding and provided feedback to facilities for benchmarking.	
2. Provided professional education through the Lactation Institute. This year's videoconference focused on problems encountered by obese women.	
3. Continued support of breastfeeding in low income women through the WIC program.	
4. PCAP and MOMS require discussion about infant feeding during prenatal care and in the early postpartum period.	
5. Community Health Workers promote breastfeeding with their clients. In 2004, 64.4% were breastfeeding at hospital discharge and 47.1% were breastfeeding at 6 weeks postpartum.	
6. Comprehensive Prenatal/Perinatal Services Network conducted workshops on the importance of breastfeeding. An important goal is to eliminate disparities in breastfeeding rates.	
7.	
8.	
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10.	

b. Current Activities

No major changes took place.

The Department is currently implementing a Statewide Perinatal Data System that will allow, among other t
assessments of breastfeeding rates and trends. Positive breastfeeding policies and practices in hospitals a
settings are promoted through periodic provider surveys and feedback about how practices compare to reg
BWH continued to distribute materials on best practices to support breastfeeding.

c. Plan for the Coming Year

No major changes are planned.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003
Annual Performance Objective	18	80	95	
Annual Indicator	16.0	61.0	92.3	
Numerator	41355	156000	231123	
Denominator	258449	255529	250343	
Is the Data Provisional or Final?				Provis
	2005	**2006**	**2007**	**2008**
Annual Performance Objective	100	100	100	

Notes - 2004
2004 data are unavailable.

a. Last Year's Accomplishments

• New York continued its dramatic improvement in newborn hearing screening rates since the initiation of th Hearing Screening Program.
• From October 2003 through September 2004, 98.5% of infants discharged from hospitals were screened (214,443/217,628). It is also significant to note that the age at referral of children with hearing loss to the sta Intervention Program decreased from 12.65 months in 2000-01 (prior to implementation of newborn hearing to 4.14 months in the 2002-03.
• During this reporting period, the Department continued to support hospital-based newborn hearing screen technical assistance, and maintained databases with contact information and data reports from facilities rec newborn hearing screening programs. Program staff and Data Unit staff maintained data reporting requirem refine data collection and management protocols.
• Early Intervention Guidance Memorandum 2003-03 on Newborn Hearing Screening was disseminated on guidance memorandum contains information on newborn hearing screening, the program requirements for birthing centers, and guidance on the role of the Early Intervention Program in facilitating follow-up for infan based Newborn Hearing Screening Programs.
• Program staff provided ongoing training and technical assistance to local Newborn Hearing Screening Pro local Early Intervention Programs. Quality Improvement efforts were targeted at data collection from the sta hospitals/birthing centers.
• Data collection continued to improve based on new data management guidelines.
• Infants in whom hearing loss was suspected were referred to the Early Intervention Program.
• Although the Community Health Worker Program does not screen for hearing loss, the program initiated th States Questionnaire (ASQ) in 2001. This is a parent-completed developmental screening tool. Through thi Community Health Worker program identified issues related to the child's development that could include is program made referrals to the Early Intervention Program, as appropriate.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	D
1. 98.% of newborns were screened for hearing loss prior to hospital discharge in 2004.	

2. Children in whom hearing loss is suspected are referred to the Early Intervention Program.
3. The average age of referral has declined from 12.56 months in 2000-2001 to 4.14 months in 2002-2003.
4. The Department continued to support local programs through technical assistance and periodic reissuance of program guidance.
5. Currently, all birthing hospitals have systems for testing, tracking and reporting newborn hearing screening.
6.
7.
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10.

b. Current Activities

Current Activities -- Activities continue as above.
• Currently, all hospitals have systems for testing, tracking and reporting newborn hearing screening. DOH
technical assistance to hospitals and other constituents on newborn hearing screening program implementa
• DOH continues to reinforce links between newborn hearing screening and the Early Intervention Program
an Early Intervention Guidance Memorandum on Newborn Hearing Screening.
• Award winning public education/parent education materials on newborn hearing screening were develope
facilities. Materials were translated into six languages.

c. Plan for the Coming Year

Plan for the Coming Year -- No major changes are planned.
• Continue efforts to establish data-driven quality assurance and review protocols, and to continue provisior
on newborn hearing screening for hospitals and other constituents, with an emphasis on follow-up for infant
initial hearing screening and/or who are suspected of having a hearing loss. Follow-up rates for infants who
screen were approximately 73% in the first two years of program operation, and technical assistance efforts
improving the re-screen rate.
• Dissemination of clinical practice guidelines on assessment and intervention for young children with heari
which will facilitate expansion of training on issues related to hearing loss in young infants to other groups,
intervention service providers, physicians and primary health care providers.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003
Annual Performance Objective	4	10	8	
Annual Indicator	10.5	9.3	9.9	
Numerator	486000	425000	461000	
Denominator	4638000	4565000	4663000	
Is the Data Provisional or Final?				Final
	2005	**2006**	**2007**	**2008**
Annual Performance Objective	9	8.5	8	

Notes - 2002

Numerator and denominator are not available for the year 2001

Notes - 2003

2003 data not yet available.

Notes - 2004

2004 estimated data are not yet available.

a. Last Year's Accomplishments

• Children birth to age 19 were eligible for MA at 133% of FPL.
• Since November 2000, pregnant women and infants were eligible for Medicaid at or below 200% of poverty mothers enrolled in PCAP were MA-eligible for at least the first year of life. PCAPs also referred to program Plus and/or Family Health Plus as appropriate. The Department developed an application for all programs t application process.
• Eligibility for Family Planning coverage was/is available up to 200% of poverty, regardless of previous pre Under this waiver, the Federal government pays 90%, the State 10%, and there is no local share. FPBP sc family for eligibility for public insurance.
• Facilitated enrollers were available statewide to assist families with public insurance enrollment processes
• Children's Medicaid was named Child Health Plus A to avoid the stigma associated with Medicaid.
• Families at or below 250% of the Federal Poverty Level were eligible for Child Health Plus B (New York's Insurance Program). Families over 250% of FPL were eligible for participation at full premium.
• Comprehensive Prenatal/Perinatal Services Networks facilitate the implementation of Medicaid Managed catchments area. Many Networks were facilitated enrollers for health insurance programs. Networks provid and education regarding Managed Care and have the ability to identify new and emerging issues related to
• All MCHSBG funded programs were required to facilitate enrollment in insurance.
• Children with Traumatic Brain Injury injured before the age of 18 were eligible for Medicaid under a specia
• CSHCN who did not have a source of insurance were assisted by the CSHCN Program to enroll in an insu eligible.
• In 2004, 12% of the children entering the CHWP did not have any form of health insurance. Of these child subsequently enrolled in Medicaid and 14.6% were pending at the time of data collection; 7.2% of children Health Plus at entry, 66.7% of those eligible were subsequently enrolled and 26.7% were pending at the tim continues a downward trend. In 2002, 17% and in 2003, 15% of the children entering the Community Healt not have any form of health insurance. In 2003, 53% of these children were subsequently enrolled into Med pending at the time of data collection; of the children not eligible for Medicaid, 62% of those eligible were su Child Health Plus (21%were pending at the time of data collection).
• All children identified as uninsured and underinsured by the Childhood Lead Poisoning Prevention Progra referred to appropriate local public insurance enrollment source.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	D
1. All Title V and Division of Family Health programs are required to facilitate enrollment in insurance programs.	
2. All counties in NY have assistance available for enrolling in public insurance programs.	
3. The NYSDOH website, Growing Up Healthy Hotline and several other hotlines provide information about public insurance programs.	
4. The Physically Handicapped Children's Program provides financial assistance to children whose circumstances do not allow enrollment in public insurance or whose services are necessary, but not covered by private insurance.	
5. New York has a number of special Medicaid waivers that allow expanded access to the program. (See text.)	

6. Healthy Children New York increased the number of child health promotion specialists who are asses child care organizations to access insurance programs for their staff and clients/families.
7.
8.
9.
10.

b. Current Activities

Current Activities -- New York continues to implement changes to eligibility levels.
• Children ages one through five years are eligible for Medicaid at 133% of the Federal Poverty Level for tw continuous coverage, even if their family's income exceeds eligibility levels during that year. Children ages age are eligible for Medicaid at 100% of the Federal Poverty Level after April 1, 2005.
Current Activities -- New York continues to implement changes to eligibility levels.
• Information on eligibility is on our DOH website and available through the Growing Up Healthy Hotline.

c. Plan for the Coming Year

Plan for the Coming Year -- No major changes are planned. Information on eligibility is on our DOH website the Growing Up Healthy Hotline.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service p*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003
Annual Performance Objective	87	87	89	
Annual Indicator	83.1	85.7	87.5	
Numerator	1341815	1395907	1550279	
Denominator	1615309	1627880	1770911	
Is the Data Provisional or Final?				Final
	2005	**2006**	**2007**	**2008**
Annual Performance Objective	95	95	95	

a. Last Year's Accomplishments

• 93.4% of Medicaid-eligible children received a service paid by the Medicaid Program in 2004, compared t in 2002. New York reviewed its EPSDT standards. EPSDT is called Child/Teen Health Plan in New York.
• Title V was involved with the development of a new EPSDT/Child Teen Health Program Provider Manual. Pediatrics standards of care were adopted, except where State law contravenes. The new Provider Manual attention to preventive care and services for children and stresses the need to adhere to periodicity schedu services.
• Dental fees rose over the last few years. Title V staff continue to try to get the word out on enhanced fees case management projects to test methods of improving dental provider enrollment in public insurance prog
• The Perinatal Data System sped enrollment in Medicaid of infants born to Medicaid-eligible mothers.
• The Community Health Worker Program provided enabling services to assist children and pregnant wome and sustaining contact with the health care system.
• The School Health Program assessed insurance status on enrollment, when children receive an initial ass Medicaid is billed for eligible services for those students where MA is indicated as the insurer. Approximate health center enrollees had Medicaid coverage.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	D
1. See above.	
2. Continue to investigate workforce issues as they relate to access to care for Medicaid-enrolled children.	
3. Continue to promote enrollment of providers into the MA program.	
4. Implement dental case management projects; collect data; determine possibilities for expansion of the model.	
5.	
6.	
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8.	
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10.	

b. Current Activities

• Title V has been involved with the development of an EPSDT/Child Teen Health Program Provider Manua
Pediatrics standards of care are being adopted, except where State law contravenes.
• The Provider Manual makes the case for attention to preventive care and services for children and stresse
periodicity schedules for preventive services.
• Bureau of Dental Health and Division of Family Health staff are working with the Office of Medicaid Manag
Health Networks on the issue of distribution of dental providers and encouraging more dentists to see Medi
• The Childhood Lead Poisoning Prevention Program has been working with Office of
Medicaid Management (OMM) to attempt to determine numbers/percentages of MA children tested for lead
pay for screening and in some managed care plans, home visits by local health department lead staff for ca
reduction services. The program is working with OMM to secure MA reimbursement for environment inspec
child's home.

c. Plan for the Coming Year

Plan for the Coming Year -- No major changes are planned.
• Title V will assist with distribution of the new EPSDT manual.
• Continue working on dental provider issues with partners and stakeholders.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003
Annual Performance Objective	1.3	1.35	1.3	
Annual Indicator	1.5	1.5	1.6	
Numerator	3976	3800	3892	
Denominator	258471	253545	250691	
Is the Data Provisional or Final?				Provis

	2005	2006	2007	2008
Annual Performance Objective	1.4	1.3	1.2	

Notes - 2002

Data are not available for 2002

Notes - 2003

2003 data is not available for this measure.

Notes - 2004

2004 estimated data is not available.

a. Last Year's Accomplishments

• Poor spacing of pregnancies contributes to poor birth outcomes. Through funding from Title X and Title V, Programs provided services including comprehensive reproductive health service to 341,532 women and a community education and outreach was conducted across the state.
• Timely, risk-appropriate, coordinated, comprehensive prenatal care was provided to all Prenatal Care Ass and MOMS Program enrollees. PCAP and MOMS required adherence to Part 85.40 standards of prenatal c care plans serving Medicaid women were required to adhere to these comprehensive standards, as well. Tl quality prenatal care and appropriate level of care mandated by the standards was shown to reduce low birt Medicaid women, particularly minority women, when compared to non-participants. In studies comparing M care under these programs with Medicaid women receiving other types of prenatal care, PCAP and MOMS better birth outcomes, and these outcomes were better even at the lower birth weights. Presumptive eligibil entry into care.
• WIC directly promoted the birth of healthy infants by preventing low birth weight. In 2003, the percentage c 7.9% among NYS WIC participants, compared to 8.9% of WIC participants nationwide, and compared to a birthweight rate which was also 7.9%.
• The Growing Up Healthy Hotline linked women with prenatal, nutrition, psychosocial and supportive servic healthy pregnancy and improved birth weights.
• The Infant Mortality Review process contributed epidemiologic information to promote healthy birth outcon prenatal risk assessment, and to encourage follow-up for all high-risk pregnancies.
• The Comprehensive Prenatal/Perinatal Services Networks and Healthy Start grantees addressed low birth collaboration with a variety of health and human services providers, focusing on low birth weight as a seriou communities and monitoring and disseminating actual data on incidence in their communities. Networks als appropriate sites of delivery for high-risk pregnant women.
• Prenatal genetics counseling and screening services were provided to approximately 24,000 women and services can identify a genetic or other congenital defect in the fetus before birth, enabling the parents, phy make available any necessary interventions before the birth.
• Of the pregnant women entering CHWP, 49% were already engaged in prenatal care. Of those women wh assisted to receive prenatal care within 1 month of entry to the program, and the remainder entered prenata month after entry into the CHWP.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	D
1. Continue to monitor issues related to multiple births and design and implement policies accordingly.	
2. Continue to promote spacing of pregnancies to improve birth outcomes through the Family Planning Program.	
3. Continue to provide timely, risk-appropriate, comprehensive, coordinated prenatal care through PCAP, MOMS, and all Medicaid providers.	
4. Continue to promote early WIC enrollment for all eligible, low-income pregnant women.	

5. The Growing Up Healthy Hotline links women with prenatal, nutrition, psychosocial and supportive services.
6. Prenatal genetics counseling services were provided to approximately 24,000 women and families.
7. Continue to monitor the perinatal redesignation implementation.
8.
9.
10.

b. Current Activities

• Timely, risk-appropriate, coordinated, comprehensive prenatal care continues to be provided to all Prenata Program (PCAP) and MOMS Program enrollees with adherence to Part 85.40 standards of prenatal care. A serving Medicaid women also adhere to these comprehensive standards.
• WIC continues to promote the birth of healthy infants by preventing low birth weight.
• The Growing Up Healthy Hotline links women with prenatal, nutrition, psychosocial and supportive service healthy pregnancy and improved birth weights.
• The Infant Mortality Review process contributes epidemiologic information to promote healthy birth outcon prenatal risk assessment, and to encourage follow-up for all high-risk pregnancies.
• Poor spacing of pregnancies contributes to poor birth outcomes. The Family Planning Programs, funded b provide direct services, including comprehensive medical exams and a full range of contraceptive services.
• The Comprehensive Prenatal/Perinatal Services Networks and Healthy Start grantees addressed low birth collaboration with a variety of health and human services providers, focusing on low birth weight as a seriou communities and monitoring and disseminating actual data on incidence in their communities. Networks als appropriate sites of delivery for high-risk pregnant women.
• Genetics services can identify a genetic or other congenital defect in the fetus before birth, enabling the pa birth facility to make available any necessary interventions before the birth.
• Following the recent re-designation process for all birthing hospitals in the State, hospitals are able to prov as well as neonatal, care for high-risk women and their pregnancies. All birthing hospitals have appropriate levels of care.
• The Statewide Perinatal Data System provides real-time internet-based data to providers, networks and lo on the occurrence of high-risk births. It is not yet fully operational in New York City.

Last year and current:
• The Department completed a re-designation process for all birthing hospitals in the State. Under this proc required to be able to provide maternal/obstetrical, as well as neonatal, care for high-risk women and their p

c. Plan for the Coming Year

Plan for the Coming Year -- No major changes are planned.
• Community Health Worker and Comprehensive Prenatal/Perinatal Services Networks will be re-procured.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003
Annual Performance Objective	4.5	5	4.8	
Annual Indicator	5.3	5.4	5.3	
Numerator	68	70	68	
Denominator	1287544	1287544	1279332	

Is the Data Provisional or Final?				Provis
	2005	**2006**	**2007**	**2008**
Annual Performance Objective	4.2	4.1	4.1	

Notes - 2002

Data are not available for 2002

Notes - 2003

2003 data is not available for this measure.

Notes - 2004

2004 estimated data are not available.

a. Last Year's Accomplishments

Last Year's Accomplishments

• Bureau of Injury Control and the Public Health Information Group made suicide data available and perform for use in planning.

• The Office of Mental Health (OMH) was given the lead in all suicide prevention activities in the state. OMH prevention campaign, which was presented to the Maternal and Child Health Services Block Grant Advisory programs had access to the campaign and associated materials.

• Teen alcohol use is correlated with suicide attempts. The New York State Office of Alcohol and Substance (OASAS) recently released a new campaign entitled, "Underage drinking: Not a minor problem." The packa and resource directories. MCHSBG Advisory Council members were also presented with this package. Title to the campaign and associated materials.

• The School Health Program, included an evaluation for suicide risk as a part of the initial health assessme services, including crisis intervention, were available through the school-based health center or by referral. been made for more intensive consultation or treatment. School staff, family members and other students w consultation and education. Approximately 16% of SBHC visits indicated emotional issues as a primary rea

• The School Health Program, in conjunction with SED and OMH, continued to operate an expanded schoo initiative in seven schools. This initiative co-located a comprehensive mental health services clinic in seven based health center to provide a range of psychological support, education, consultation and treatment for s School staff education and support were also an integral component of the model.

• Assets Coming Together (ACT) for Youth focused community attention on asset-building activities for you risk-taking behaviors. Through these community collaborations, ACT for Youth developed youth forums on sexual behaviors, as well as peer education materials, conflict resolution training to train peer mediators, ar

• NYS continued implementation of the Lesbian, Gay, Bisexual and Trans-gendered Health Initiative. Over l under this initiative are focused on issues related to gay and lesbian youth and issues with alcohol, substan inflicted injuries. Data from other states indicate that gay, lesbian and bisexual youth are approximately 4 ti attempt suicide than their heterosexual counterparts.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**D**
1. Surveillance data is continuously available and additional analyses are performed as needed relative to suicide, suicide attempts and use of teen use of alcohol.	
2. Continued to work with partners in the Office of Mental Health and the Office of Alcoholism and Substance Abuse Services.	
3. The School Health program continues to include suicide risk as a part of initial assessment and to provide a wide array of comprehensive mental health services.	
4. ACT for Youth focuses community attention on asset-building as a way to reduce high risk behaviors.	

5. DOH continued implementation of the Lesbian, Gay, Bisexual and Transgendered Helath Initiative.	
6.	
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9.	
10.	

b. Current Activities

Current Activities
• The lead on suicide prevention activities continues to be the Office of Mental Health.
• There have been no major changes in DOH programming.

c. Plan for the Coming Year

• Continued collaboration with the Bureau of Chronic Disease Prevention and Adult Health, Bureau of Injury
Mental Health and Office of Children and Family Services.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliv*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003
Annual Performance Objective	81	81	83	
Annual Indicator	77.8	77.2	84.6	
Numerator	3093	2935	3401	
Denominator	3975	3800	4018	
Is the Data Provisional or Final?				Provis
	2005	**2006**	**2007**	**2008**
Annual Performance Objective	90	91	92	

Notes - 2002
Data are not available for 2002

Notes - 2003
2003 data are not available.

Notes - 2004
2004 estimated data not available.

a. Last Year's Accomplishments

Last Year's Accomplishments
• NYSDOH completed a perinatal re-designation process of all 157 obstetrical hospitals in the State to ensu
women and newborns have timely access to the appropriate level of perinatal care. Their designation was b
capability to provide care for pregnant and postpartum women and newborns. The last time a designation p
1985, and designations were based solely on newborn care.
• NYSDOH implemented 11 Regional Perinatal Forums that joined the expertise of the hospital provider cor
expertise of the non-hospital community to bring a public health perspective to the regionalization process.
Centers and Comprehensive Prenatal/Perinatal Networks collaborated in the development and the governa
Forum membership includes a range of community-based agencies that provide prenatal care, local March
Health Worker Programs and others. There is one Forum in each borough of New York City, one on Long Is

Upstate.
• Bureau of Women's Health worked with New York City Department of Health and Mental Hygiene to imple
that brought together the issues from each of the borough Forums.
• All hospitals with Level I, II or III designations are required to by State Hospital Code to have perinatal affil
Regional Perinatal Center that is easily accessible within two hours. There must also be patient transfer agı
transfer criteria, policies and procedures for maternal-fetal, postpartum and newborn transfers and back tra
required to cooperate in outreach, education and training activities and in onsite quality of care reviews by t
Center.
• In 2002 and 2004, the Bureau of Women's Health engaged in a statewide pregnancy-related media camp
awareness of the importance of prenatal care.
• All PCAPs conducted risk assessment on all patients to identify any high risk factors that warrant appropri
had/have agreements with tertiary care centers for referral of high risk women for appropriate level of care.
receive an appropriate level of service prior to admission to the hospital (perinatologist, maternal-fetal medi
also receive inpatient services at a hospital that is capable of providing the level of care required for the pre
infant.
• The cytogenetics laboratory provided prenatal and postnatal cytogenetic analysis, identifying congenital a
enabling treatment.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	D
1. All 157 birthing hospitals in New York have completed the perinatal services redesignation process to ensure that all women have aces to timely and appropriate levels of prenatal care. Staff continue to monitor the implementation of the new/renewed	
2. 11 Regional Perinatal Forums were implemented. These forums join the expertise of the regional perinatal center with the community knowledge of the Comprehensive Prenatal Perinatal Services Networks and other non-hospital providers to bring a public	
3. All birthing hospitals have perinatal affiliation agreements with hospitals of differing levels.	
4. Perinatal services standards contained in Part 85.40 of the Public Health Law require risk assessment of all prenatal patients.	
5. The cytogenetics laboratory provided prenatal and postnatal cytogenic analysis, identifying congenital abnormalities and enabling treatment.	
6.	
7.	
8.	
9.	
10.	

b. Current Activities

Current Activities -- Activities continue as above.
• DOH is continuing to implement Regionalization and Perinatal Regional Forums.
• Perinatal Forums identified a number of public health concerns that on which they plan to work, including:
improving prenatal care and using vital statistics data to identify areas where services are needed.
• No major changes are planned.

c. Plan for the Coming Year

Plan for the Coming Year
• No major changes are planned.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003
Annual Performance Objective	76.5	75	77.5	
Annual Indicator	72.8	73.0	73.0	
Numerator	172625	172126	172109	
Denominator	237019	235789	235766	
Is the Data Provisional or Final?				Provis
	2005	**2006**	**2007**	**2008**
Annual Performance Objective	85	86	87	

Notes - 2002

Data are not available for 2002

Denominator excludes births to women with unknown prenatal care.

Notes - 2003

2003 data are not available for this measure.
Total births excludes births to moms with unknown prenatal care.

Notes - 2004

2004 estimated data are not available.

a. Last Year's Accomplishments

• The Maternal Mortality Study found lack of prenatal care in the first trimester was associated with high risk additional data was gathered about barriers to care.
• The Comprehensive Prenatal/Perinatal Services Networks worked to increase the percent of women ente first trimester. In addition to the statewide Hotline, Networks had/have local toll-free numbers, web sites, res other mechanisms to provide pregnant women with information and referral to prenatal care. Networks iden to the service system, and with the Consortium, worked to increase accessibility and the quality of the local system.
• PCAP and MOMS encouraged early enrollment in prenatal care, offered presumptive eligibility, and ensur services.
• Public awareness campaigns and the Healthy Baby Hotline helped raise awareness of the need for early
• An important collaboration between Title V and the AIDS Institute is the Community Action for Prenatal Ca This initiative sought to engage pregnant, HIV positive women in early prenatal care. CAPC was closely coo Community Health Worker Programs in overlapping regions of New York City and Buffalo.
• The Community Health Worker Program is a premier enabling service. Specially trained individuals from t and populations educated pregnant women and parents about health needs and instruct/role model the app health care system. They provided enhanced outreach services to engage families and individuals into the assisted them to sustain relationships with appropriate providers.
• Of the pregnant women entering CHWP, 49% were already engaged in prenatal care. Of those women wh assisted to receive prenatal care within 1 month of entry to the program, and the remainder entered prenata month after entry into the CHWP. Of the total number of pregnant women in CHWP, 75.7% entered prenata trimester, 14.9% in second, 2.7% in third; 1.5% did not receive prenatal care and there are no data for 5.2% in CHWP.
• The School Health Program provided pregnancy testing and reinforced the need for early prenatal care. A on-site or through referral to back-up facilities. Nearly 2% of visits indicated pregnancy or contraception as
• The Family Planning Programs made early referrals for women testing positive for pregnancy, thereby imp

access to prenatal care in the populations served.
• The Bureau of Women's Health conducted a statewide media campaign to increase awareness of the imp
into prenatal care and increase awareness of where low-income women can go to obtain prenatal care in 2
for prenatal care to the hotline increased fo

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	D
1. PCAP and MOMS Programs encourage early enrollment in prenatal care, offered presumptive eligibility, and ensure timely initiation of prenatal health and supportive services.	
2. The Community Health Worker Program continues to enable very high risk women to enroll and maintain participation in prenatal care.	
3. Community Action for Prenatal Care (CAPC), a joint venture of Title V and the AIDS Institute, engages high-risk, pregnant HIV+ women to enroll and maintain enrollment in prenatal care.	
4. Title V collaborates with Healthy Start programs in the State on issues of mutual concern, such as early entry to prenatal care.	
5. The School Health Program provides onsite pregnancy testing and either onsite prenatal care or referral to back-up facilities. Students testing negative are counseled and offered or referred to programs that can provide appropriate contraceptive met	
6. Statewide media campaigns promote early entry into prenatal care.	
7.	
8.	
9.	
10.	

b. Current Activities

There were no major changes.
• The Safe Motherhood Initiative, collaboration between the American College of Obstetricians and Gyneco
NYSDOH, recommended early entry into high-quality care to deter maternal mortality. The collaborative co
accurate reporting of maternal deaths.

c. Plan for the Coming Year

Plan for the Coming Year -- No major changes are planned.
• PCAP/MOMS will continue to encourage early enrollment in prenatal care, offer presumptive eligibility, an
of services. Potential barriers to early entry are addressed on an ongoing basis as they arise and PCAPs/M
about ways to facilitate early entry to care. Providers are offered quarterly meetings with regional office staf
state. Funds will be sought to repeat the prenatal care enrollment campaign.
• Outreach and Education projects will target women who would typically enter prenatal care late or not at a
minimize perceived barriers, financial or otherwise, to prenatal care, engaging women early in their pregnar
reducing the need for high risk, more expensive care. For very high-risk women, the Community Action for
Project will continue.
• Educational materials and media messages will continue to be available through the Bureau of Communit
• Pregnant school-based health center clients were entered into prenatal care immediately. School-based h
followed-up to ensure continued enrollment and continuity of care. References were made as needed for a
• Engaging women into early prenatal care is a priority of the Networks. In addition to the statewide Growing
Networks have local toll-free numbers, resource directories or other mechanisms to provide pregnant wome
referral to prenatal care. Networks also identify gaps and barriers in the service system, and in collaboratio
work to increase accessibility and the quality of the local perinatal service system.

• The Community Health Worker and Comprehensive Prenatal/Perinatal Services Network Programs will be

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *Percent of Live Births Resulting from Unintended Pregnancies*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003
Annual Performance Objective	34.4	33.9	33.5	
Annual Indicator	37.8	38.8	34.3	
Numerator				
Denominator				
Is the Data Provisional or Final?				Provis
	2005	**2006**	**2007**	**2008**
Annual Performance Objective	32.9	32.8	32.7	

Notes - 2002

2002 data is based survey results. Numerator and denominator data is not available.

Notes - 2003

Numerator and denominator data are not available for this measure (survey data).

2002 and 2003 data are not yet available.

Notes - 2004

2004 estimated data are not available.

a. Last Year's Accomplishments

• The Family Planning Program implemented outreach for the Family Planning Benefits Program. This prog
planning services to individuals under 200% of poverty who met eligibility requirements. Eligibility did/does
pregnancy or previous Medicaid status, and provides a full range of contraceptive services and reproductive
outreach initiative included a statewide satellite teleconference and training, a brochure, and production of a
to allow providers to train new staff.
• The Family Planning Program continued to provide access to reproductive health care through the Family
Program. This program provided family planning benefits to eligible women for 24 months after a pregnancy
• Family Planning Programs provided over 9,909 community education sessions, reaching approximately 1
addition, to education, the program provided comprehensive reproductive health care, including screening f
cancer, STD screening and treatment, and HIV counseling and testing.
• The Community Health Worker Program provided family planning information to all women of childbearing
to family planning services. They then followed-up to see that services were received.
• The Community-Based Adolescent Pregnancy Prevention Program's worked to reduce teen pregnancies
codes across New York State. C-BAPPP promoted abstinence and the delay of sexual activity among teens
educational, recreational and vocational opportunities as alternatives to sexual activity; taught assertiveness
access to family planning and comprehensive reproductive health services.
• The School Health Program provided risk assessment for sexual activity as part of the initial assessment a
guidance is offered. Pregnancy testing was done, where indicated. Students had access to family planning
by referral. Students are also referred early for prenatal services; practitioners co-manage the student's pre
health centers provided services to approximately 32,000 female students ages 15-19.
• The Comprehensive Prenatal/Perinatal Services Networks implemented several activities related to decre
through provision of family planning information and education on the importance of inter-conceptional care
access schools to provide structured educational programs addressing reproductive health and pregnancy

developed a peer-mentoring program to encourage and model healthy behaviors in adolescents. Others ha
such as teen pregnancy coalitions to address local issues related to adolescent pregnancies. Some Networ
agencies for Community-Based Adolescent Pregnancy Prevention Programs.
• NYSDOH funded 37 Abstinence Education Projects.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	D
1. Continue to support Family Planning Programs	
2. Continue to support the Community-Based Adolescent Pregnancy Program	
3. Continue to provide Abstinence Education	
4. Continue to provide family planning education in the Community Health Worker Program	
5. Continue to assess for risk of unintended pregnancy in the School Health Program	
6. Continue to support Comprehensive Prenatal/Perinatal Services Networks	
7. Continue to support assets building and youth development through ACT for Youth	
8. Continue outreach to low-income families	
9. Continue participation in collaborative efforts to reduce uninintended pregnancy	
10. Continue to implement the Family Planning Waiver and enhance outreach through MA providers	

b. Current Activities

Current Activities
• The new Family Planning waiver is implemented. The Family Planning Program implemented a comprehe
education initiative, targeting Medicaid providers, in order to increase provider awareness of the Family Pla
The initiative will include a statewide satellite teleconference and training, a brochure and production of a tr
allow providers to train new staff.
• No major changes took place.

c. Plan for the Coming Year

Plan for the Coming Year --
• No major changes are planned.

State Performance Measure 2: *Hospitalilzation Rate for Asthma in Children 1 to Age 14*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003
Annual Performance Objective	420	340	325	
Annual Indicator	342.4	344.2	345.4	
Numerator	12601	12666	12397	
Denominator	3679816	3679816	3589371	
Is the Data Provisional or Final?				Provis
	2005	**2006**	**2007**	**2008**
Annual Performance Objective	250	245	235	

Notes - 2003

2003 data are not available for this measure.

Notes - 2004

2004 estimated data not available.

a. Last Year's Accomplishments

• The Asthma Coordinator continued to play a pivotal role in coordinating asthma prevention and control eff
Title V and the Asthma Coordinator worked with the Office of Medicaid Management, the Office of Manage
Environmental Health, the Division of Chronic Disease Prevention and Adult Health, the State Education De
City Department of Health (which has its own major asthma initiative), the Pediatric Pulmonary Center, the
Group and Child Health Plus.
• Asthma hospitalization rates were updated for year 2004. Rates were generated by age, sex, race/ethnicit
regional, and county levels. This information was available on the HIN and HPN.
• User-friendly asthma treatment guidelines were formulated and distributed across the state. The New Yor
Asthma Guideline Expert Panel finalized the Clinical Guideline for the Diagnosis, Evaluation, and Managem
Children with Asthma in 2003. Endorsements were obtained from several groups across the spectrum of go
plans, and professional societies.
• The Bureau of Child and Adolescent Health continued to award funds to nine regional asthma coalitions a
improve the diagnosis, treatment and prevention of childhood asthma, and provide care coordination servic
in an effort to reduce asthma-related morbidity and mortality. Newest coalitions are in the South Bronx and
coalitions sponsored over 200 public events over the last year and trained more than 12,000 health care pr
• Under the Columbia Collaborative Projects, MCHSBG funded asthma-related initiatives that targeted redu
minority communities where there are very high rates of the disease. The manual for child care providers th
year was implemented this year.
• School-Based Health Centers developed for each affected student in coordination with primary care physi
clinical and educational interventions.
• Child health promotion specialists provided technical assistance to child care providers and other child-se
prevention and treatment of asthma.
• An educational needs assessment was completed in January 2004 using a web-based survey instrument.
completed the survey, which confirmed results of earlier focus groups.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	D
1. Asthma activities are coordinated across the whole Department by the Asthma Coordinator. All clinical, environmental, research and laboratory services pertaining to asthma are aligned.	
2. Asthma hospitalization rates are updated and made available for planning and targeting of services via the HPN and the HIN.	
3. Asthma treatment guidelines and a best practices manual were formulated and distributed. Training followed.	
4. Nine regional asthma coalitions continued to coordinate care for asthmatic children, provide educational offerings and work to improve diagnosis, treatment and prevention of asthma.	
5. School-based health centers developed asthma action plans for each of the asthmatic children enrolled in their programs in collaboration with primary care providers.	
6. Child health promotion specialists assisted child care providers and other child serving organizations with the prevention and management of asthma.	
7. In Bushwick, 7,120 parents, teachers and children were educated in reducing asthma episodes, what constitutes treatment and where to get help.	
8. The Harlem Family Asthma Program provided comprehensive case management to asthmatic	

children and provided state-of-the-art asthma care training to health providers.	
9.	
10.	

b. Current Activities

• The regional childhood asthma coalitions continue to provide asthma education, training and case manag
• The program is implemented training around statewide guidelines.
• Age-specific asthma rates are generated on the zip code level.
• Asthma is currently a topic included in Healthy Children New York Training.
• School-Based Health Centers provide an individualized care plan for enrolled students with asthma.
• 7,120 Bushwick teachers, parents and pediatric asthma patients in 100 schools, daycares and Community
(CBOs) were educated on how to reduce asthmatic episodes, what constitutes treatment and where they ca
• The Harlem Family Asthma Program provided comprehensive care and case management of 27 children
period. The program also provided training on "state of the art" asthma care to 67 pediatric health care staf

c. Plan for the Coming Year

• Continue to distribute Best Practice Manuals and provide training.
• Continue to provide asthma education, training and case management activities through Asthma Coalition
• Continue asthma as a topic for Child Health Promotion Specialist Training.
• Continue School-Based Health Center activities.
• No major changes are planned.

State Performance Measure 3: *Percent of women who reported smoking during pregnancy*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003
Annual Performance Objective	12.5	12	11.5	
Annual Indicator	16.6	14.3	14.6	
Numerator				
Denominator				
Is the Data Provisional or Final?				Provis
	2005	**2006**	**2007**	**2008**
Annual Performance Objective	10	9.5	9	

Notes - 2002

PRAMS survey data used. Numerator and denominator are not available.

Notes - 2003

Numerator and Denominator data are not available for this measure (survey data).

2002 data are being used as a proxy for 2003 and 2004 data.

Notes - 2004

2004 data estimates unavailable.

a. Last Year's Accomplishments

• These data are tracked and reported via PRAMS. NYS is a PRAMS state.
• PCAP promoted healthy behaviors during pregnancy. PCAPs provided information regarding the impact o
and the fetus and have developed various programs to deal with smoking, including individual counseling a

other programs that support smoking cessation.
• The School Health Program continued to screen for tobacco use and make appropriate referrals, including and smoking cessation programs, and to counsel students accordingly.
• The Comprehensive Prenatal/Perinatal Services Network's priorities included developing and implementin the number of women who smoke or use other substances during pregnancy. Networks provided education and human services providers on ways to assist women to enhance healthy behaviors, including smoking c
• Although the Community Health Worker Program did not keep not specific data on smoking, an important Health Worker was to provide education for women to increase their understanding of behaviors that pose a included the use of tobacco. The Community Health Worker will not only provided this information, but also referrals for those women seeking assistance in this area, including accompanying them to care, if necessa
• Family Planning Programs referred for smoking cessation.
• All Migrant Health and American Indian Health Program providers screened for tobacco use and make ap
• School-based health center staff continued to screen all enrollees, including pregnant adolescents, for tob counseling and make appropriate referrals.
• New York State recently passed a tough, new Clean Indoor Air Act.
• NYS Medicaid covers/covered smoking cessation products and programs.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	D
1. Efforts to reduce prenatal smoking are a part of larger efforts to reduce the use of tobacco products all across NY.	
2. Some of NY's tobacco control efforts include: Reality Check campaigns, Community Tobacco Control Coalitions, Tobacco Cessation Centers, NY Smokefree Workplace, and hotline and website support for those who wish to quit.	
3. Smoking data for this measure are tracked and reported via PRAMS. Data are also analyzed from BRFSS and the Youth Tobacco Survey.	
4. School-based health centers screen for tobacco use, provide counseling and make appropriate referrals.	
5. Comprehensive Prenatal/Perinatal Services Networks developed and implemented various programs in their regions to reduce the number of women smoking during pregnancy and in the presence of their infants.	
6. Community Health Workers educate women on the danger of smoking to the fetus and to infants who inhale secondhand smoke. Appropriate referrals are provided.	
7. Family Planning Programs screen their clients for tobacco use and refer clients to smoking cessation.	
8. All Migrant Health and American Indian Health Program providers screen tobacco use, counsel and refer clients to smoking cessation.	
9. Medicaid in NYS covers smoking cessation products and programs. The Smokers Quit Line can also arrange for eligible smokers to obtain these products free of charge.	
10. Health care providers, including physicians, dentist and dental hygienists, can fax referrals to the Quitline for follow-up. The Quitline received over 45,000 calls in 2004.	

b. Current Activities

Current Activities
• New York continues to invest heavily in anti-smoking messages.
• The Tobacco Control Program monitors implementation of the Clean Indoor Air Act.
• A number of the Program's partners implement the EPA's "Smokefree Home Pledge."
• The Tobacco Control Program funds the American Cancer Society for "Make Yours a Fresh Start," a prog

pregnant women.
• No major changes.

c. Plan for the Coming Year

No major changes are planned.

State Performance Measure 4: *Teenage Pregnancy Rate for Girls Ages 15-17*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003
Annual Performance Objective	43.4	43.5	42	
Annual Indicator	43.8	42.4	40.0	
Numerator	16501	15969	14948	
Denominator	376698	376698	374080	
Is the Data Provisional or Final?				Provis
	2005	**2006**	**2007**	**2008**
Annual Performance Objective	36	35	34	

Notes - 2003

2003 data is not available for this measure.

Notes - 2004

2004 estimated data are not available.

a. Last Year's Accomplishments

• MCHSBG funds supported 59 local Family Planning Programs across the state. These programs serve lo
women, or approximately one third of those estimated in need, and approximately one third of which were u
program strove to ensure that each pregnancy was intended. Family Planning Programs provided commun
information services, comprehensive medical exams, a full range of contraceptive services, and special cou
• Community-Based Adolescent Pregnancy Prevention Program maintained a roster of about 300 peer cou
zip codes to effectively counsel their peers, dispel common myths about sexuality, encourage discussions a
responsible sexual behavior, and provide accurate information about how and where to obtain primary and
services. C-BAPPP worked with schools and parents to increase communication skills and sexual literacy.
• 37 Abstinence Education and Promotion contractors provided abstinence education, mentoring, counselin
to promote abstinence from sexual activity in 15- to 19-year-olds. The initiatives initially focused on junior hi
students and those groups at highest risk for bearing children out-of-wedlock. Funding included a statewide
campaign to support the community-based initiatives. The "Not Me, Not Now" campaign was purchased fro
viewed an average of 23 times by 86.28% of all teens in the State in ten major markets.
• The Networks implemented several activities related to decreasing adolescent pregnancies through provis
information and education on the importance of inter-conceptional care. Some Networks accessed schools
educational programs addressing reproductive health and pregnancy care. One Network had a peer mento
encourage and model healthy behaviors in adolescents. Others developed groups such as teen pregnancy
local issues related to adolescent pregnancies. Some are lead agencies for the Adolescent Pregnancy Prev
• The Comprehensive Prenatal/Perinatal Services Networks provided conferences on adolescent pregnanc
communities. Each Network takes a localized approach to the issue.
• The School Health Program provided risk assessment on enrollment, consultation, anticipatory guidance,
(either directly or by referral), pregnancy testing, prenatal care (either directly, by co-managing care, or by r
consultation and education).
• The Community Health Worker Program educated women of childbearing age regarding family planning, r

planning services and followed up to determine whether appointments are kept and services are received.
• The "Growing Up Healthy" Hotline linked women (including adolescents) with prenatal, nutrition,

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	D
1. Title V and X funds support 59 local Family Planning Programs across the state.	
2. The Community-Based Adolescent Pregnancy Prevention Program maintained a roster of about 300 peer counselors in 54 of the highest-risk zip codes in the State.	
3. 37 Abstinence Education contractors provided abstinence education, mentoring, counseling and adult supervision to 15- to 19-year olds.	
4. Abstinence Education media campaigns focused on junior high/middle school students.	
5. Comprehensive Prenatal/Perinatal Services Networks implemented several activities related to decreasing adolescent pregnancy rates, some of which included school-based programs. One utilized the peer approach.	
6. The School Health Program provided risk assessment on enrollment, counseling, and anticipatory guidance, and family planning services, some through referral and some directly.	
7. The Community Health Worker Program educated women about family planning, referred women to family planning services, and follow-up to ensure services were received.	
8. ACT for Youth utilized an assets-based Youth Development approach to reduce risk-taking behaviors among youth. ACT for Youth stresses teen involvement in programming.	
9. Ra[e Crisis Centers provide compassionate treatment to the victims of sexual assault.	
10. Please see those activities listed under State Performance Measure 1 on Unintended Pregnancy.	

b. Current Activities

Current Activities: No major changes occurred.

Last year, continued:

family planning, psychosocial and supportive services, which contributed to healthy pregnancies and impro
• Teens may be eligible for PCAP/MOMS. Many teens were enrolled in 2004.
• ACT for Youth utilized an assets-based approach to reduce risk-taking behavior among youth.
• The Department continued to work with other agencies, including the Office of Children and Family Servic
Education Department.
• The 76 Rape Crisis Centers worked to reduce the incidence of rape and sexual assault, as well as to ensu
compassionate treatment of victims to reduce debilitating consequences once an assault has occurred.
• Please refer to materials presented under State Performance Measure 01 on unintended pregnancy.
• The "Not Me, Not Now" Campaign aired statewide in all larger media markets and at times when teenage
ads. Promotional materials are available free of charge through out communications outlet.

c. Plan for the Coming Year

No major changes are planned.

State Performance Measure 5: *The percent of low income kids ages 2-4 enrolled in the WIC pro*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003
Annual Performance Objective				
Annual Indicator	16.3	15.9	16.8	
Numerator	11980	10729	29564	
Denominator	73496	67477	175978	
Is the Data Provisional or Final?				Final
	2005	**2006**	**2007**	**2008**
Annual Performance Objective	15	14	14	

a. Last Year's Accomplishments

Please note that this is a newly-selected State Performance Measure as of 2004. This measure replaces a Health Status Indicator.

• A project to impress physicians with the importance of tracking Body Mass Index (BMI) was initiated unde Medicine Residency and the Bureau of Child and Adolescent Health. A provider education mailing was des procured. The American Academy of Pediatrics District II New York State and New York State Academy of agreed to co-sign the cover letter and allow use of their academy logos. An evaluation component was desi
• Height and weight measurement was added to Oral Health Surveillance activities.
• The Division of Nutrition continued to implement "Eat Well, Play Hard."
• The Department's Physical Activity and Nutrition (PAN) grant continued to focus provide leadership for str address overweight and physical activity.
• The WIC Program provided nutrition information to all participants.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	D
1. A provider education mailing to all family practice and pediatric physicians included BMI wheels and growth charts.	
2. Height and weight measurements were added to the oral health surveillance protocol. Measurements were collected on 3rd graders.	
3. The Division of Nutrition continued to implement "Eat Well, Play Hard."	
4. The WIC Program continued to provide infant and child nutrition information to all participants. FITWIC is being expanded.	
5. Title V programs will review the new statewide physical activity and nutrition/obesity and overweight prevention plan and will collaborate on implementation.	
6. NY is developing and expanding its infrastructure for obesity and overweight prevention. The Statewide plan includes a Health and Fitness by Age 5 Programs and a new Active 8 Kids! initiative.	
7. Division of Chronic Disease Prevention is piloting a community-level intervention approach in collaboration with Head Starts in the inner-city Albany area aimed at reduction of screen time and healthy nutritional practices.	
8. 100-200 schools will carry out the School Health Index to carry out environmental and policy changes.	
9. NYSDOH continues to engage multiple partners in overweight/obesity prevention: the Education Dept., SHIFT, Team Nutrition, ffice of Children and Family Services, insurers, Cornell University, Head	

Start, to name a few.
10. There is on-going support for PedNSS, PRAMS, PNNS, YRBS, BRFSS and 3rd grade surveillance.

b. Current Activities

Current Activities -

• The Department is developing a Physical Activity and Nutrition Plan that will guide future activities in this c stakeholders are participating. The plan was recently released.

• Division of Chronic Disease Prevention and Adult Health began testing new interventions that utilize conc and diffusion of innovation on a community-wide level. In this model, fourteen Head Start centers will be tar participate in the intervention, and ten of which will serve as controls. Interventions will include assessment policies, environmental assessment, collaborative policy development, and development of training session and families. Specifically, environmental and policy changes will promote an increase in physical activity, a viewing and a decrease in language and policies that promote overeating and inactivity. A community comp program changes.

c. Plan for the Coming Year

Plan for the Coming Year --

• Activities will be shaped by the new statewide Physical Activity and Nutrition Plan.

State Performance Measure 6: *Percent of infants who are put down on their backs to sleep.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003
Annual Performance Objective	61	62.5	65	
Annual Indicator	63.4	68	65.8	
Numerator				
Denominator				
Is the Data Provisional or Final?				Provis
	2005	**2006**	**2007**	**2008**
Annual Performance Objective	80	82	84	

Notes - 2002

2001 data na

Notes - 2003

Numerator and Denominator data are not available for this measure.

2003 data are being used as a proxy for 2004.

Notes - 2004

2004 estimated data unavailable.

a. Last Year's Accomplishments

• Again, there was a decline in the number of SIDS deaths through a comprehensive statewide education a associated with SIDS through the Back to Sleep Campaign.

• The Department continued to implement the "Back to Sleep" first kicked off by First Lady Libby Pataki in 1 produced T-shirts imprinted on the front and back with, "Put me on my back to sleep." These T-shirts and a were distributed thorough all hospitals in the State.

• SIDS Prevention Information Cards (the same cards that were made available with the T-shirt) were reprir
Spanish.
• SIDS Prevention Posters were developed after staff learned of the lack of awareness of the "Back to Slee
care community. To help child care providers learn of the importance of sleep positioning and other SIDS p
poster listing the information was designed. Posters were distributed to every registered childcare provider
reminder to place babies on their backs to sleep. Other SIDS prevention messages were included, too.
• Statewide training efforts continued. Police, fire fighters, emergency medical personnel and public health r
appropriate responses to SIDS. The Department oversaw notification of infant deaths by funeral directors, c
examiners. The Center for Sudden Infant Death at SUNY Stony Brook and its satellites provided training ar
services. For families that had experienced any infant death in the last year, they provided a 1-800 "warm li
information and referral to self-help groups and other mental health services. The Center also arranges a h
health nurse. Newsletters were sent on a regular basis, and were a very popular item. The Center also rele
materials about the dangers of placing infants to sleep in adult beds.
• A special SIDS prevention project was initiated among the St. Regis tribe, with excellent results.
• In May 2002, a new State law was passed amending the autopsy provisions of the Public Health Law and
protocols for the performance of autopsies in cases of sudden, unanticipated death in infants under the age
were developed and implemented.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	D
1. There was continued implementation of "Back to Sleep" statewide. Materials are available from multiple sources reinforcing the "Back to Sleep" message. See http://www.health.state.ny.us/diseases/conditions/sids/.	
2. SIDS Prevention posters were distributed to the every registered provider in the child care community.	
3. NYSDOH oversaw the notification of infant deaths by funeral directors, medical examiners and coroners.	
4. The Center for Sudden Infant Death at SUNY Stonybrook and its satellites provided education and support services for parents. They provide a 1-800 warmline for self-help, support and referral.	
5. Police, fire fighters, emergency medical personnel, and public health nurses are educated on appropriate responses to SIDS.	
6. The SID Center arranged for visits to bereaved families from Public Health Nurses.	
7.	
8.	
9.	
10.	

b. Current Activities

Current Activities
• No major changes were made.

c. Plan for the Coming Year

No major changes are planned.
The contract for provision of SIDS prevention and bereavement services is due for reprocurement.

State Performance Measure 7: *Hospitalizations for Self-Inflicted Injuries for 15-19 Year Olds*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003
Annual Performance Objective	92.7	86	83	
Annual Indicator	0.1	0.1	0.1	
Numerator	1137	1195	1287	
Denominator	1287544	1287544	1279333	
Is the Data Provisional or Final?				Provis
	2005	**2006**	**2007**	**2008**
Annual Performance Objective	0.1	0.1	0.1	

Notes - 2003

2003 data are not available for this measure.

Notes - 2004

2004 estimated data are not available.

a. Last Year's Accomplishments

•See National Performance Measure 16. This measure was selected as a state performance measure beca attempts are higher than rates of completion would indicate.

•All School-Based Health Centers provided psychosocial assessment beginning with the initial visit. Studen offered individualized education regarding safety issues and abuse, and mental health services were made indicated. Potential abuse and neglect cases were reported. Staff followed-up on all referrals and behaviora

•Through community collaborations, the ACT for Youth Initiative has developed:
• Youth forums on violence, abuse and risky sexual behaviors;
• Peer education for violence prevention;
• Conflict resolution training to train peer mediators; and
• Mentoring programs.
•The Community-Based Adolescent Pregnancy Prevention Program employed a youth development/youth

•Emergency Medical Services for Children improved pre-hospital care for children and youth.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	D
1. See information provided for National Performance Measure # 16.	
2. All school-based health centers provide individual psychosocial and risk assessments beginning with the initial visit. Students can be referred for further intervention.	
3. ACT for Youth developed youth forums on violence, abuse and risky behavior, peer education, conflict resolution, peer mediation, and mentoring programs.	
4. All Community-Based Adolescent Pregnancy Prevention Programs and Abstinence Education Programs employ a Youth Development and Youth Empowerment framework.	
5. Grantees under the Lesbian, Gay, Bisexual and Transgendered Health Initiative focused on issues related to alcohol, substance abuse and self-inflicted injuries.	
6.	

7.	
8.	
9.	
10.	

b. Current Activities

Current Activities - There were no major changes in activity.
• Bureau of Child and Adolescent Health is currently working with the Office of Mental Health and other part elements of a statewide suicide prevention plan.
• School-Based Health Centers continue to assess students for suicide risk, and are implementing enhance services.
• Youth development continues to be a focus of all youth-focused activities.

c. Plan for the Coming Year

Plan for the Coming Year
• No major changes planned.

State Performance Measure 8: *Percent of High School Students who had five or more drinks of once in the Last Month*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003
Annual Performance Objective	23	22	21	
Annual Indicator	NaN	34.7	34.7	
Numerator	0			
Denominator	0			
Is the Data Provisional or Final?				Final
	2005	**2006**	**2007**	**2008**
Annual Performance Objective	19	19	18	

Notes - 2002

2002 data are not available. Data are from the YRBS survey which collects data every other year.

Notes - 2003

Numerator and Denominator data is not available for this measure (survey data).

Notes - 2004

2004 data are not availabe. Data is from the YRBS survey. The next year data will be available will be 2005

a. Last Year's Accomplishments

Please note that this measure was changed in the last submission. In previous years, the indicator tracked drinking alcohol at least once in the last month.
• DOH/Title V staff continued to collaborate with our state Office of Alcoholism and Substance Abuse Servic substance abuse and alcohol-related prevention policy. Beginning in 1999, OASAS involved multiple humai county level in identifying alcohol and substance abuse risk and protective factors, and in strengthening and partnerships for alcohol and substance abuse prevention. Fifteen (15) counties were funded for three years implement countywide, prevention- and results-focused work plans. These work plans identified, re-directed and local resources for a comprehensive, multi-system approach to alcohol and substance abuse preventio

• OASAS implemented a new statewide prevention campaign entitled, "Underage Drinking: Not a Minor Pro
promoted the campaign to health care providers.
• The focus of ACT for Youth, (Assets Coming Together for Youth) was to empower youth and to prevent al
sexual activities, all of which are associated with low self-esteem; poor decision making related to sexual be
substance use and abuse; poor nutrition and eating disorders. Community Development Partnerships targe
populations (substance abusing/using, those in foster care and group homes, homeless and runaway, orph
incarcerated, HIV affected/ infected, migrant, parenting, with disabilities, with different sexual preferences, i
programs, and Black/African American, Hispanic/Latino, Asian/Pacific Islander and Native American).
• Over half of the Lesbian, Gay, Bi-Sexual, Trans-gendered Health Initiative contractors targeted issues rela
substance abuse and self-inflicted injury.
• PCAP/MOMS clients are assessed for alcohol and substance abuse issues; referrals are made according
• The initial assessment in school-based health centers includes questions about tobacco and alcohol use.
and educated accordingly. Referral is available.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	D
1. All youth-focused programs with in DOH employ a Youth Development framework that promotes asset development and reduction of risk-taking behavior.	
2. The Office of Alcoholism and Substance Abuse Service (OASAS) developed a new campaign called "Underage Drinking: Not a Minor Problem." The campaign has been promoted to Title V programs.	
3. DOH continued collaboration with the OASAS on substance abuse and alcohol-related policy. Local collaborations resulted from the effort to consolidate local planning.	
4. ACT for Youth empowers youth to improve decision-making related to sexual behavior, drugs, alcohol, poor nutrition and eating disorders.	
5. Grantees under the Lesbian, Gay, Bisexual and Transgendered Health Initiative focused on issues related to alcohol, substance abuse and self-inflicted injuries.	
6. PCAP and MOMS clients are assessed for alcohol and substance abuse issues and results of assessments are entered into the plan of care.	
7. School-based health centers include in their initial asessment questions related to alcohol and drug use. Plans of care include appropriate counseling, treatment and/or referral.	
8.	
9.	
10.	

b. Current Activities

Current Activities
• No major changes.
• All Title V related programs continue focus on youth empowerment/ youth development.

c. Plan for the Coming Year

Plan for the Coming Year
• All Title V related programs will continue to employ a youth empowerment/ youth development focus.

State Performance Measure 9: *Percent of High School Students Who Smoked Cigarettes in the*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2
Annual Performance Objective	26.	23	19	
Annual Indicator	27.4	21.3	21.3	
Numerator				
Denominator				
Is the Data Provisional or Final?				
	2005	**2006**	**2007**	**2**
Annual Performance Objective	5	5	5	

Notes - 2003

Numerator and Denominator data is not available for this measure.
Even year data are from the Youth Tobacco Survey; odd year data are from the YRBS.

Notes - 2004

2004 data are not available.

a. Last Year's Accomplishments

• These data are tracked via the Youth Risk Behavior Survey (YRBS).
• New York has one of the highest tobacco excise taxes in the nation. Raising the price of cigarettes discou
• A tough indoor air law was passed, banning smoking in public places, including restaurants and bars.
• The Tobacco Control Program continued to identify youth to become active in unannounced compliance c to minors. (New York State provided $2 million to this enforcement effort so that every retail outlet would re compliance check.) Not only is age of the buyer an issue, in New York there is a state law requiring that all behind the counter.
• The Tobacco Control Program funds 62 Youth Partnerships for Health (YPH) to help youth resist peer pre social and community anti-tobacco activities. These partnerships sought to "de-normalize" the use of tobac of heavy advertising to youth done by tobacco companies.
• The State also funded 26 local Tobacco Control Coalitions in every county of the state to mobilize commu activities such as banning billboards that promote tobacco near schools and playgrounds.
• The Tobacco Control Program also assisted communities to pass local ordinances on smoking in public p products from the reach of youth, and to reduce tobacco advertising in areas frequented by youth.
• The Tobacco Control Program began in 2001 planning for inclusion of tobacco education in School-Basec centers were funded to provide tobacco education and cessation.
• The initial assessment in school-based health centers included questions about tobacco and alcohol use. educated accordingly. Referral for smoking cessation is available. The Program also funded 14 Tobacco Us
• PCAP, MOMS and the Community Health Worker Program assessed prenatal clients for tobacco use and cessation and other counseling/health teaching.
• Comprehensive Prenatal/Perinatal Services Networks created awareness of the dangers of smoking, part
• The Tobacco Control Program maintained youth empowerment "Reality Check" contracts
• The Tobacco Program participated in the Oral Health Coalition and formulation of the Oral Health Plan.
• New York made smoking cessation assistance available through a toll-free hotline and purchase of smoki available through Medicaid.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities
1. New York State has one of the highest tobacco excise taxes in the nation; higher prices discourage teer NYSDOH publishes a guide for tobacco merchants on the public website. See

http://www.health.state.ny.us/nysdoh/smoking/main.htm
2. There is an active Reality Check program with Youth Action Partners. See http://www.health.state.ny.us/prevention/tobacco_control/community_partners/reality_check_youth_action_
3. Tobacco Cessation Centers are available in every region of NYS. See http://www.health.state.ny.us/prevention/tobacco_control/community_partners/tobacco_cessation_centers.
4. NY's Tobacco Control Program is partnering on the Smoke-Free Movies Project.
5. The Tobacco Control Program provides extensive training to its grantees and a regional communication ensure technical assistance needs are met.
6. The Tobacco Control Program monitors tobacco industry marketing and has provided a CD-ROM on the technical assistance to grantees.
7. All local grantees must align their strategies and activities with the Statewide Tobacco Control Plan.
8. The Tobacco Control Program issued an RFA for program to reach populations with tobacco-related he disparities.
9.
10.

b. Current Activities

Current Activities
• No major changes took place.

c. Plan for the Coming Year

Plan for the Coming Year
• Title V will continue to collaborate with Division of Chronic Disease Prevention and Adult Health, who is th public health programming.
• The Department will continue to effectively implement the Clean Indoor Air Act.
• Youth partnership activities will focus on effective interventions to prevent and reduce tobacco use.

State Performance Measure 10: *Percent of children in the birth year cohort who were screened the age of two.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003
Annual Performance Objective	74	75	78	
Annual Indicator	62.4	65	66.5	
Numerator				
Denominator				
Is the Data Provisional or Final?				Provis
	2005	**2006**	**2007**	**2008**
Annual Performance Objective	87	87	87	

Notes - 2002

Numerator and denominator data not available for 2000 and 2001.
Each data year is for the birth cohort born two years prior to that year.
For example, the 2001 data is for the 1999 birth cohort.
Data is for NYS excluding NYC

Notes - 2003

Data for 2002 and 2003 are provisional.
Data if for New York State (excluding NYC)

Notes - 2004

2004 data are not available.

a. Last Year's Accomplishments

• The Childhood Lead Poisoning Prevention Program coordinates efforts to prevent, detect and treat childh
educates the public and health professionals about prevention, early detection and appropriate medical ma
lead poisoning; ensures that families of children with lead poisoning are given appropriate advice and assis
eliminating sources of lead within the child's environment; provides lead-safe interim housing while lead haz
removed; and collects and analyzes statewide data on the extent and severity of childhood lead poisoning.
• In New York, lead testing is done primarily by the child's medical provider. State and local health departme
conducted PBII (Physician Based Immunization Initiative) visits to monitor for lead screening when they che
immunization compliance. Providers were given feedback on missed opportunities for both lead testing and
administration.
• The Childhood Lead Poisoning Prevention Program had contracts with 57 local health departments to pro
programs and provide care coordination.
• Additional funding to the Childhood Lead Poisoning Prevention Program was used to assist local health de
high incidence areas, improve laboratory reporting, perform a Medicaid match of cases, produce an annual
prevention efforts, perform community outreach and working through the Division of Housing and Communi
information sharing between local health departments and housing agencies.
• Seven teaching hospitals served as Regional Lead Resource Centers.
• Nine local health departments and community-based organizations provided interim lead-safe housing.
• Local health departments and State Health Department District Offices provided environmental assessme
control services.
• Because NYS has more pre-1950's housing than any other state, New York has a universal screening pol
providers are required to screen children for high blood lead at ages 1 and 2.
• Wadsworth Center operates a public health lead screening laboratory where blood from children througho
for lead levels.
• New York has regulations concerning prenatal screening for lead.
• Examination of the percentage of children born between 1994 and 1999 who received a blood lead screer
age showed New York's screening rates remained steady.
• Program and partners continued to try to increase screening using strong media campaign.
• Media campaigns were developed and implemented to increase screening efforts.
• Promoting an understanding of the need for lead screening and the importance of primary health care is a
The CHWP continued to strive to improve the percent of children who receive lead screening.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	D
1. The Childhood Lead Poisoning Prevention Program coordinates and funds efforts to prevent, detect and treat childhood lead poisoning; they promote early and appropriate screening.	
2. Through adding lead screening checks to the Physician-Based Immunization Initiative, the providers are given feedback about rates of lead testing in their practices and how to avoid missed opportunities for screening.	
3.	
4.	
5.	
6.	

7.	
8.	
9.	
10.	

b. Current Activities

Current Activities

• NYS has implemented a plan to Eliminate Childhood Lead Poisoning by 2010, consistent with federal requ
screening rates is a focus area of the Plan. Examination of the percentage of children born between 1994 a
blood lead screening test by 24 months of age shows New York's screening rates have remained steady at
additional 25% of children are screened beyond age two for an overall total screening rate of 88%. In the ye
children enrolled in Medicaid Managed Care plans were screened for blood lead levels by 24 months of age
improvements. Program and partners try to increase screening using strong media campaign.
• Child care health consultants provide technical assistance to child care providers to increase screening fo
• Community Health Workers and Healthy Neighborhoods Workers continue to educate parents in high-risk
for lead screening and follow-through on high lead results.
• Wadsworth Center operates a public health lead-screening laboratory where these specimens are tested.

Last year, continued:

• WIC and PCAP continued to stress the need for preventive services for infants, including lead screening.
• Lead screening was provided to the 1800 children attending migrant day care.
• Local health department programs actively linked lead poisoned children with special health care needs to
services, if available in the communities. In most cases, a lead poisoned child is automatically given a deve
and/or referred to local Early Intervention (EI) program to ensure care coordination
• The Childhood Lead Poisoning Prevention Program was re-funded by the CDC at reduced funding.
• The Healthy Children New York Program increased number of child care health consultants who assist ch
tracking lead screening.

c. Plan for the Coming Year

Plan for the Coming Year

• Release new data.
• Continue with implementation of statewide Lead Elimination Plan.
• No major changes.

E. OTHER PROGRAM ACTIVITIES

Data, Surveillance & Public Health Information

• Vital Records processed over 75,000 birth records; 40,000 death records; 35,000 marriage records; 5,000
records; and 18,000 genealogy-related requests.
• The SSDI project provided support to the CSHCN program and assisted in the development of the CSHCN
system will be linked with other child health data sets.
• The SSDI project worked with all Title V programs and the Integrated Child Health Information System to id
opportunities for collaboration.
• The Maternal Mortality Study activities focused dissemination and promotion of the protocol for maternal m
form, medical record abstraction form and instruction manual. Professionals and specialists were recruited t
review teams and received approval under Section 206(1)(j) of the Public Health Law, which provides confid
purpose of improving the quality of medical care.
• Because the Growing Up Healthy Hotline operated 24/7 and utilizes various languages, anyone throughou
to the Hotline for information at any time. In 2004, the hotline responded to 59,191 calls, in the following area

and cervical screening 0.1%, Child Health Plus 5.7%, child/adult care food program 0.4%, early intervention 1.1%, Family Health Plus 3.0%, family planning 3.0%, farmer's market 4.1%, food and nutrition program 0.5 immunizations 0.4%, Medicaid for adults 4.0%, Medicaid for children 1.1%, newborn screening 0.6%, pregn 0.9%, summer food program 6.0%, WIC 53.7%, WIC complaints 1.3%, other 2.1%. WIC email component is completed this year. Information about domestic violence and the Osteoporosis Regional Centers was adde during the year. Although there is no way to connect the calls with an increase of services and better outcon a 24-hour service to provide this information will ultimately result in better outcomes.

• Congenital Malformations Registry staff visited 12 hospitals in FFY 2004 to demonstrate and promote the r (HPN) electronic reporting option. All 12 hospitals and an additional 5 hospitals contacted by conference cal electronic reporting in 2004. This new Internet reporting option eases the burden on hospital staff and has in accuracy of reporting to the registry.

• Data from the Fetal Alcohol Syndrome (FAS) surveillance was published in a paper comparing the FAS su reporting of FAS to the registry.

• Active surveillance of neural tube defects (NTDs) in Health Service Area (HSA)6 and HSA 1 continued. Da project was submitted to the National Birth Defects Prevention Network (NBDPN) for the NTD rapid ascertai

• New York hosted the National Birth Defects Prevention Study analysts meeting. Approaches to the analysi this meeting.

Dental Health

• The Fluoride Supplementation Program provided educational training on early childhood oral health issues centers and professional educators.

• Supplemental fluoride was distributed across the state to school and Head Start centers in non-fluoridated the consent of their parents.

• The Bureau of Dental Health and multiple stakeholders from across the state have completed the Statewid

• The Bureau of Dental Health, in partnership with the New York State Dental Society and the NYS Head St undertook a new initiative to improve the oral health of Head Start and Early Head Start children and familie forums in conjunction with the implementation phase of the NYS Oral Health Plan.

Education

• The Genetics Centers provided educational opportunities to medical students (approximately 200 program professionals (about 300 programs), people with a diagnosed genetic condition (about 80) and the general p

• The New York State Preventive Medicine Residency Program provided academic and/or practicum training three with strong interests in MCH. Residents contributed to a wide variety of initiatives in maternal and child education to raise pediatric providers' awareness of the importance of tracking Body Mass Index; developme obstetricians about oral health care during pregnancy; analysis of reasons for recent decline in number of bi production of a satellite broadcast promoting breastfeeding in minority communities and among obese wome Program received a four-year grant from the American Cancer Society.

• The Dental Public Health Residency Program graduated three residents from its statewide program. The P accreditation status and proceeded to collaborate with the other four dental residency programs in New York

Prenatal/Perinatal Services

• All of the state's obstetrical hospitals received their final perinatal designation. The Department continued t approval for the revised perinatal regionalization regulations and in developing a process to assess quality o Centers (RPCs) and their affiliate hospitals. The regulations provided clearer guidance to the RPCs and affil the role of the RPC in quality improvement responsibilities with their affiliate hospitals, and the types of wom safely and appropriately managed at differing levels of hospi

F. TECHNICAL ASSISTANCE

Due to multiple priorities, New York was unable to participate in Region 2 or HRSA technical assistance in F recommend a second "large states" technical assistance meeting to discuss issues of mutual concern.

V. BUDGET NARRATIVE

A. EXPENDITURES

Completion of Budget Forms: Please refer to budget columns on Forms 2, 3, 4, and 5 for a summary of state income as it contributes to the MCH Partnership.

Principles for Allocation: Also, please refer to the Principles for Allocation of Maternal and Child Health Servi of the Needs Assessment.

Due to ongoing allocation reviews and expenditure disbursement analyses, reallocations have resulted with unobligated balance. Carryover in last year's application was noted in the "Unobligated Balance" column. In though not all spent at the time of submission. NYSDOH was given guidance from HRSA that these funded unobligated. Therefore, budgeted (FFY 2006) and expended (FFY 2004) amounts will be shown on Form 3 displayed as unobligated balance. The total Federal allocation is committed to program services and will no unobligated.

Concerted efforts are made to reduce carryover balance by addressing areas of need as indicated in emerg mothers and children. Program areas receiving increased fund allocations include: nutrition and physical act overweight initiatives, and a Graduate Medical Education grant to foucs on emerging public health issues fo

B. BUDGET

Maintenance of Effort: New York meets and exceeds the maintenance of effort requirements of Section 505 Department of Health plans continued Title V funding for the following efforts in FFY 2006:

- The Adolescent Health Initiative, including ACT for Youth and Youth Risk Behavior Surveillance;
- The Adolescent Health Coordinator;
- American Indian Health Program Community Health Workers;
- Asthma Coalitions;
- Children with Special Health Care Needs Program, including the Physically Handicapped Children's Progra Program;
- Columbia Collaborative Projects;
- Community-Based Adolescent Pregnancy Prevention;
- Congenital Malformations Registry;
- Family Planning;
- The Genetics Program and Newborn Metabolic Screening;
- SUNY School of Public Health MCH Graduate Assistantship Program;
- Health Communications;
- Immunization Registry activities;
- Infant and Child Mortality Review;
- Injury Prevention;
- The Lactation Institute;
- Lead Poisoning Prevention;
- Migrant Health;
- Newborn Hearing and Metabolic Screening;
- Parent and Consumer Focus Groups;
- The Statewide Perinatal Data System;
- Preventive Dentistry Initiatives and the Dental Residency Program, including an expanded dental sealant p Oral Health in Pregnancy;
- Public Health Information;
- School-Based Health Centers and School Health Infrastructure;
- STD Screening and Education;
- Universal Newborn Hearing Screening;
- Vital Records; and
- Women and Disabilities Teleconference.

The Monroe Consolidated Child and Family Health Grant will continue in FFY 2006. Under this initiative, sev

county with an integrated work plan.

Methodology: Effort is made to match funding to the level of unmet need, and to address the four layers of th target populations. Because funded programs often take more than one structural approach to targeted nee appropriations are proportioned out to reflect percentage of effort in infrastructure-building, population-based direct health care services. Program appropriations also take into account the "30-30-10" requirements of Ti

New York State uses a fair method to allocate Title V funds among individuals and areas identified as having child health services. The State uses its MCH funds for the purposes outlined in Title V, Section 505 of the S MCHSBG Advisory Council assists the Department in determining program priorities and has been instrume the application process. The Council developed in 1984 a document entitled "Principles and Guidelines for t which was updated and affirmed each year. New York is using an Oracle-based system of gathering progra delineates sources of funds for the programs for only the second year.

The methodology used to identify State expenditures for MCH-related programs has not changed:

• Appropriate cost centers, representing specific areas of activity related to MCH, are identified.
• Data for the appropriate fiscal periods are obtained from the Office of the State Comptroller (OSC).
• Data for selected cost centers are extracted on a quarterly basis.
• Quarterly data is compiled from relevant cost centers to reflect expenditures made during the federal fiscal
• All expenditure data represent payments made on a cash (vs. accrual) basis.
• Transactions associated with specific grants are identified and tracked through appropriation, segregation, processes to permit proper and complete recording of the utilization of available funds.
• Identifying codes are assigned to record these transactions by object of expense within each cost center.

Any amount payable to the State under this title from allotments for this fiscal year which remain unobligated carried forward and obligated in the following fiscal year. The Department and the Office of the State Compt documentation for Block Grant funding and expenditures consistent with Section 505(a) and Section 506(a)(an audit trail. The grant expenditures are recorded through standard OSC documents.

Reporting requirements and procedures for each particular grant are instituted to comply with conditions spe award.

The state share in MCH services is considerable, more than meeting the requirements for state match. State MCH include:

• AIDS Adolescent Research Network, Adolescent HIV Prevention, Pediatric and Maternal Initiative, Materna Homeless and Run-Away Women and Children, HIV Services to Homeless and Run-Away Adolescents;
• Child Care;
• Early Intervention;
• Family Planning;
• Genetic Screening and Human Genetics;
• Health Care Reform Act of 2000 Allocations;
• Immunization, Vaccine Distribution and State Aid for Immunization;
• Lead Control and Prevention, Lead Poisoning Prevention Local Assistance and Lead Interim Housing;
• Physically Handicapped Children's Treatment Program/Children with Special Health Care Needs Program;
• School-Based Health Centers;
• State Aid to Local Health Departments;
• SIDS and Infant Death; and
• Tobacco Settlement Dollars.

Federal sources of MCHSBG dollars other than the block grant include:

• Abstinence Education;
• Centers for Disease Control and Prevention (Lead, Immunization, Public Health Information Infrastructure; Health Systems);

• CISS grants;
• Early Intervention, Part C;
• Family Planning;
• Rape Crisis;
• STD/fertility;
• SPRANS Grants;
• SSDI Funds;
• TANF Funds;
• Early Childhood Comprehensive Systems planning grant; and
• Integrated Women's Health Initiative.

A regional analysis of Title V external contracts shows that 64.75% of funds are contracted for the metropoli most of the State's population is located; 15.65% goes to the Western New York area, our second most pop Central New York; and 8.16% goes to the Northeastern and Capital District areas of the state. These breako the proportion of New York's population residing in each of these areas.

The State more than meets "30-30-10 Requirements" for 30% allocation to primary and preventive care to c 33.73%), for 30% for children with special health care needs ($16,629,243 or 38.92%) and under 10% for ac 5.02%).

VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. S
sheet for each state performance measure; to view these detail sheets please refer to Form 16
online application.

VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state
appear as an attachment to this section.

IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to t